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Aliveness is the experience of living fully engaged within the world from a relational stance of our Thou (I-Thou). Martin Buber (1958) spoke of aliveness as the experience of being completely present. Buber inferred that when we are present, we are relationally present from our *Thou* to another's *Thou*. Aliveness, however, does not remove the individual from the world in which they live, it is not an ultimate state of consciousness, instead it is a sustained full-lived experience. Yet, for many people there are barriers in the pursuit of aliveness, one being social class and socioeconomic status (SES) – complicated constructs to define. Researchers have long linked social class and socioeconomic status with health problems, including mental illness (McSilver Institute for Poverty Policy and Research, 2019, May 20). Although some research exists around SES, a gap remains in understanding the implications to clinical treatment. Further information on culturally appropriate interventions for individuals of low SES is limited (Cook & Lawson, 2016; Clark, Cook, Nair, & Wojick 2018).

SES is essential to an individual's worldview and culture, making it compulsory for counselors to include SES into their approach to treatment. With the gap between SES groups only continuing to grow, developing culturally appropriate interventions for individuals of low SES is needed (Rodriguez, Baumman, & Scwhartz, 2010). Further, as highlighted by Bernal (2006), the development of a culture-specific intervention or adaptation is implemented through a phased process. This study aimed to complete the

first phase of testing the intervention within a small population—in order to best understand the nuances of this specific population.

The purpose of this study was to explore the effectiveness of the dialogical relationship e-learning modules in a sample of individuals of low SES. This study focused on the dialogical relationship as one way to enhance aliveness among individuals of low SES (Friedman, 1988). The researcher used Single Case Research Design in order to examine the effectiveness of the intervention for individuals of low SES. The study aimed to enhance relationship quality through a culturally sensitive approach. Results suggested impact in some domains such as the effectiveness of the dialogical relationship e-learning modules in teaching dialogical skills, based on participants' self-reported confidence to use these skills. One other over-arching finding of interest was a trend of relationship satisfaction decreasing as the study progressed. Somewhat surprisingly, for several of the participants for whom relationship satisfaction decreased or did not improve, Quality of Life (QoL) demonstrated an upward trend. The results of this study provided direction for future intervention development, adaptation, and implications for counselors working with individuals from low SES.

EXPLORING THE EFFECTIVENESS OF DIALOGICAL RELATIONSHIP E-LEARNING MODULES WITH INDIVIDUALS OF LOW SES

by

Angiemil Pérez Peña

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Approved by

_____
Committee Chair

APPROVAL PAGE

This dissertation, written by Angiemil Pérez Peña, had been approve by the following committee of the Faculty of The Graduate School at the University of North Carolina at Greensboro.

Committee Chair

Dr. Craig Cashwell

Committee Members

Dr. Kelley Wester

Dr. Scott J. Young

Dr. Steve Kroll-Smith

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4/20/2020
Date of Final Oral Examination

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come true, and when no one was there, you fought for the dreams that became possible as the journey became visible.

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CHAPTER I

INTRODUCTION

Overview

> People say that what we're all seeking is a meaning for life... I think that what we're seeking is an experience of being alive, so that our life experiences on the purely physical plane will have resonances with our own innermost being and reality, so that we actually feel the rapture of being alive. ~ Joseph Campbell

As Joseph Campbell alludes to in the above quote, as humans we inherently seek confirmation of being alive. As a society, it is generally agreed that humans have the right to access and pursue happiness or, in other words, experience a fullness of living that might be called *aliveness* (Kelly, 2017; Norish & Vella-Brodrick, 2007). Abraham Maslow referred to this level of consciousness and experience as a *plateau experience* (Maslow, 1964). He believed that plateau experiences - living in the fullness of life within ordinary circumstances - could be taught and would not require self-actualization as a prerequisite (Maslow, 1964).

Aliveness is the experience of living fully engaged within the world from a relational stance of our *Thou* (*I-Thou*). When individuals engage from a relationship of *I-Thou*, the self cannot be fragmented (Harding, 1974). Martin Buber (1958) spoke of aliveness as the experience of being completely present, which he inferred as being relationally present from your *Thou* to another's *Thou*. Aliveness does not remove the

individual from the world in which they live, and it is not an ultimate state of consciousness, but a sustained fully lived experience.

For many people, however, there are barriers in the pursuit of aliveness, one being social class and socioeconomic status (SES) – difficult constructs to define. Liu et al. (2004) described social class as a complex construct that incorporates different aspects of culture - values, family meanings, attitudes, beliefs, practices, and language. Social class is tied to prestige and power. Individuals belonging to a social class understand and are able to identify others within their same social class. People who are lower in the hierarchy of class have less power, prestige, and less access to resources. One barometer of social class, socioeconomic status (SES), is measured by the combination of education, income, and occupation (Liu et. al, 2004; Socioeconomic Status Office, 2019).

This study focused on the dialogical relationship - a modern expression of the *I-Thou* relationship - in considering one way to enhance aliveness among those in low-SES groups (Friedman, 1988). In this chapter, I will give an overview of social class and socioeconomic status, the impact of SES on mental health, the different needs of individuals with low SES, and the dialogical relationship. Promoting quality dialogical relationships may be one way to enhance aliveness among individuals of low SES. Thus, to conclude this chapter, I will address possible ways to fill the gap and serve the needs of individuals of low SES in support of a fuller life.

Socioeconomic Status

Socioeconomic status (SES) is the combination of education, income, and occupation (Liu et. al, 2004; Socioeconomic Status Office, 2019). According to the Bureau of Justice Statistics of the U.S. Department of Justice, SES can be calculated on single measures, such as income (NCVS report, n.d.). Therefore, for this study, SES was derived from index 3 of SES index (See Appendix E) Poverty thresholds utilized in this study were established by the Census Bureau for the year 2019 and outlined in Table 1. Only individuals at or below the poverty line were included in the study.

In general, individuals of *low SES* are considered to have less access to wealth, power, and income levels. Individuals of *middle SES*, however, have a greater educational achievement, allowing them to earn a livable income, which may allow for greater access to power - usually on a local and regional scale. Individuals of *high SES* possess an appreciable amount of wealth, usually acquired through inheritance, investments, and/or income. Additionally, they have greater access to education which allows for a greater amount of power and influence on a greater social scale (Hendrix-Sloan, n.d., 2014). An important, therefore, consideration is the diverse needs individuals of different SES carry into the counseling relationship. Thus, clients' SES should impact the approach to treatment within counseling.

Table 1

Index 3 of the Bureau of Justice Statistics U.S. Department of Justice

Persons in Family/Household	Poverty Guideline
1	$12,490
2	$16,910
3	$21, 330
4	$25, 750
5	$30,170
6	$34, 590
7	$39, 010
8	$43, 430

Source: https://aspe.hhs.gov/2019-poverty-guidelines 6/7/19

Mental Health Professionals and Client SES

For mental health professionals, the appropriateness of an intervention must reside in the context of social class and economic culture. It is necessary that members of helping professions not see clients through their own cultural lens, which includes social class and socioeconomic status (SES) (Wang, Locke, & Chonody, 2013). For instance, re-packaging an intervention developed for and only researched among those in the middle or higher SES groups dismisses the different lived experiences of individuals of low SES (Liu, 2004). The question remains, then, how is the fullness of living (or

aliveness) promoted among individuals of low SES – people who may not have the resources to attend counseling or engage in other forms of personal growth work that might facilitate fullness of living?

Interventions that do not conceptualize an individual from their economic context and culture may overlook the impacts of low SES, such as deficiency needs (e.g., food insufficiencies; Cook & Lawson, 2016). Maslow (1964) suggested that people first attend to their basic survival needs before focusing on their social, existential, and spiritual concerns, suggesting that those from lower SES groups might be more focused on survival needs. Basic needs such as food insufficiencies are related to SES and have an influence on the development of mental illnesses (Siefret, Heflin, Corcoran, & Williams, 2004). Sustained physical hunger leads to the development of an appetite for those nutrients lacked throughout our lives, creating a pattern of appetite that can last a lifetime (Young, 1961). Therefore, individuals from low SES groups focus on meeting their physical needs. Thus, concordantly supporting our understanding of the repercussions of low SES and the difficulty within low SES groups off focusing on fulfilling higher-level needs (e.g., growth needs). Maslow (1943, 1948) made the link between physiological needs (e.g., deficiency needs) and higher-level needs, such as mental health, in his hierarchy of needs theory:

> Undoubtedly these physiological needs are the most prepotent of all needs. What this means specifically is that in the human being who is missing everything in life in an extreme fashion, it is most likely that the major motivation would be the physiological needs rather than any others. A person who is lacking food, safety, love, and esteem would most probably hunger for food more strongly than for anything else. If all the needs are unsatisfied, and the organism is then dominated

> by the physiological needs, all other needs may become simply nonexistent or be pushed into the background. (p. 17)

In an exploratory study, Noltemeyer, Bush, Patton, and Berge (2010) sought to confirm Maslow's motivation theory (i.e., the hierarchy of needs) within a population of economically disadvantaged children. Notably, the authors confirmed that the higher the deficiency needs, the fewer growth needs seemed present. Children with high deficiency needs have greater difficulty in focusing on higher-level needs while basic needs remain unmet. Considering that a growing portion of our population struggles with food insufficiencies and security (approximately 40 million people; Coleman-Jensen, Rabbit, Gregory, & Singh, 2018), it is within reason that individuals from lower SES groups may be more concerned with the "physiological needs (which) are the most prepotent of all needs" (Maslow, 1948, p. 17) and attend less intently to relationship issues. Ostensibly, then, people from lower SES groups may attend less to dialogical relationships in favor of their physiological needs and, by extension, their quality of life may be compromised.

Similarly, low SES is related to poor health and lower educational achievement, both of which have repercussions on one's quality of life (Socioeconomic Status Office, 2019). Loss of employment, economic changes, and the resulting stress may trigger the onset or exacerbate symptoms of mental illness (Liam & Liam, 1978). Children from low SES households struggle with developmental markers such as language acquisition and develop at a slower rate than persons from higher SES groups (Socioeconomic Status Office, 2019). Furthermore, dropout rates from schools are impacted by inadequate education which further perpetuates low SES for individuals, families, and communities

(Socioeconomic Status Office, 2019). Additionally, the perception of economic familial stress, as well as financial constraint, is linked to emotional distress and depression in students (Mistry, Benner, Tan, & Kim, 2009). Accordingly, it is a fair assumption that individuals of low SES may not have the same access to a fullness of life as their middle and upper SES counterparts. Further, because those from lower SES groups have less access to traditional counseling services, one social context in which people encounter dialogical relationships, some may be limited in their exposure to and interest in the dialogical encounter. The challenge, then, becomes how to expose those from lower SES groups to the potential impacts of the dialogical relationships.

Dialogical Relationship Model

A central component of the dialogical relationship is the unfolding of the *between* two full individuals (Friedman, 1988). The unfolding of the *between* is what Buber (1958) and Friedman (1998) identified as the *dialogical* relationship. Friedman (1988) categorized the ontology of Buber's *between* by an experience that can only occur between two people who are each *real*; they are full expressions of their *being* and not caught in *seeming. Between* meeting is the experience of a shared reality, as if stepping into the same arena where both individuals are present and confirmed by the other. Victor Frankl (1970) concorded with Buber's belief that healing is done through dialogue and through the meeting of two individuals. This healing is present in therapeutic relationships, healthy familial relationships, and friendships (Friedman, 1988). Central to

understanding the dialogical is the foundation that it exists within relationships—with self and others.

The dialogical approach in psychology is centralized to the *relationship* as it is a relational theory (Martin, 2017). It is important to note that the term *relationship* includes both the relationships one has with others and the authentic connection with the true self (Friedman, 2008). In counseling, the dialogical approach manifests within real encounters between counselor and client and the work counselors do to facilitate client connection with the true self. Outside of therapeutic relationships, it manifests in real encounters among people in their everyday life. Friedman (2008) defined *dialogical psychotherapy* as being "therapy that is centered on the meeting between the therapist and his or her client or among family members as the central healing mode, whatever analysis, role-playing, or other therapeutic techniques or activities may also enter in" (p. 299).

At the core, the essence of a dialogical relationship – both within and outside of counseling – is summarized by Friedman (2008) as follows:

> When you embrace me as the unique person that I am and when you confront me in your own uniqueness, we confirm each other as the unique persons we are called to become. This direct contact between whole human beings gives rise to the sphere of the between. (p. 299)

Friedman (2008) posited that a large component of confirmation, that of seeing and validating another for their uniqueness, is imagining and experience their feelings and experiences. Confirmation is accomplished through the dialogical relationship which consists of*, presentness, directness, openness, and mutuality*. *Openness* is the ability of

an individual to engage with another from a genuine stance (Friedman, 2002). *Presence* or *presentness* speaks to the engagement of one individual to another where one is completely engaged (Floyd, 2010). *Directness* is the ability to speak and share thoughts and feelings clearly and authentically with others (Guerrero, 2019). *Mutuality* speaks to the bidirectionality of a relationship, where each individual is equal and contributes to the relationship in emotions and actions (Genero, Miller, Surrey, & Baldwin, 1992).

Although some may experience a fullness of life in isolation, many find fullness primarily in the context of meaningful relationships. For some, however, SES creates barriers to this experience of fullness. Social class and SES continue to be misunderstood within the counseling profession and in society at large (Liu et. al, 2004), and understanding should come with an inclusive approach that not only includes the worldview of low SES but also responds to the needs of this subgroup. For example, many people from lower SES groups do not have the resources to attend traditional counseling (Sanchez-Page, 2005). Further, even when they do attend, many counseling interventions fail to completely address issues of social class and SES (Liu et. al, 2004). In aggregate form, these stressors impact the quality of life, including relationship satisfaction, among members of low-SES groups. Individuals from low-SES populations who experience stressful life events and mental health problems are less likely to report relationship satisfaction than individuals from wealthier populations (Dakin & Wampler, 2008). Specifically, economic difficulties can aggravate mental health problems and relationship dynamics (Maisel & Karney, 2012). Maisel and Karney further warned against using interventions for low-income couples that have been normed solely on

predominately white and college-educated samples. Instead, the researchers suggested that interventions for low-SES relationships take into account an individual's contextual circumstances and include an emphasis on both mental health problems and life stresses.

Other considerations for working with low-SES groups are structural barriers that impact help-seeking behaviors. Thoits (2005) identified barriers to accessing mental health services, including living in rural areas, not having health insurance, ongoing life strains, and the stigma of seeking mental health services. Even for individuals with health insurance, the overall use of healthcare is lower among those from low-SES groups (Fiscella, Franks, Gold & Clancy, 2000). Further, Kugelmass (2016) found that individuals from middle-SES groups were less likely to receive an appointment than higher-income individuals, suggesting that biases held by psychotherapists may have an additional negative effect on mental health help-seeking. Additionally, biases against clients from lower SES groups appear to influence the diagnosis or interpretation of symptoms, which may lead to negative outcomes (Kugelmass, 2016). Therefore, more appropriate and culturally appropriate interventions are needed for individuals of low SES.

Bridging the Gap

Culturally appropriate interventions are increased by technology, which has created new opportunities to address the mental health needs of those from lower SES groups (Ralston, Andrews & Hope, 2018). Chang (2008) found online forums to be effective at reaching a greater number of traditionally underserved individuals. From a

wellness and prevention model approach, best uses of online forums include psychoeducation, self-help, and mutual help (Chang, 2005).

In particular, e-learning has garnered support in the scholarly literature as one modality of psychoeducation for reaching individuals of low SES (Usoro & Abid, 2008). E-learning can be used to provide low-cost or free access to psychoeducation. E-learning may be particularly appropriate for those in lower SES groups as it removes barriers. Although access to online information may still serve as a barrier for some, e-learning addresses critical barriers such as time, distance, and SES (Usoro & Abid, 2008). Additionally, the affordability and replicability for educators make e-learning appealing and concordant with the needs of individuals of low SES (Usoro & Abid, 2008).

E-learning is founded on the principles of open education and has grown in prominence Usoro & Abid, 2008) as evidenced by the evolution of scholarly journals such as the *International Review of Research in Open Education and Distributed Learning*. It is important to note that open and distributed education aims to address the human right that good education should be accessible to all (Stracke, 2019). This model of prevention and psychoeducation fully fits the purpose of this study: to design, implement, and evaluate dialogical relationship e-learning modules (DREM) that meet and support the needs of individuals of low SES, potentially increasing their quality of life.

Statement of the Problem

Being alive, or aliveness, can be described both biologically, and from the subjective experience of living fully in an engaged manner in day-to-day life. This concept can be understood from both an existential and relational lens. By nature, humans are relational beings (Buber 1958). Thus, the quality of our relational connectivity is influential to health and wellness (Buber, 1958; Sabarra & Coan, 2018a; Witmer & Sweeney, 1992). When examined from a negative perspective, the breakdown of relationships adversely impacts our quality of life (Sabbarra & Coan, 2018b; Walker, 2011). Buber (1958) offered a paradigm of relational connectivity in which an individual both fully sees others and allows the self to be seen. He called this the *I-Thou* relationship. The *I-Thou* relationship is the cornerstone of a dialogical relationship. Buber (1958) summarized the *I-Thou* relationship, in essence, as all real living is meeting. Four major components of the dialogical relationship emerged from Buber's work: *presentness, directness, openness,* and *mutuality* (Friedman, 2008). However, the dialogical relationship may be more easily accessed by individuals whose basic hierarchy of needs are satisfied, such that those from lower SES groups may struggle to fully realize the dialogical (Maslow, 1943). Understanding effective ways to increase relationship quality becomes imperative, particularly among individuals of low SES who experience relational distress more acutely (Maisel & Karney, 2012).

Another factor to consider is the rising of reported loneliness and its impact on mental health-giving cause for concern (Cacioppo, Grippo, London, Goossens & Cacioppo, 2015). The link between relationship quality and physical and mental health

has been well established (Buber, 1958; Genero, Miller, Surrey, & Baldwin, 1992; Sabarra & Coan, 2018a; Witmer & Sweeney, 1992). The National Alliance on Mental Illness (NAMI, n.d.) reported that, every year in the United States, 1 in 5 adults experiences a mental illness concern or issue, and 1 out of 25 adults experiences a mental illness that interferes with or impairs their daily functioning (NAMI, n.d.).

Further, mental illness and social class have been linked since as early as the 1930s (Liem & Liem, 1978). Thoits (2005) found confirmatory results that individuals of lower-income and education were more likely to report having a psychiatric condition within the last year than their sociodemographic counterparts. SAHMSA (2016) reported that "Adults aged 26 or older living below the poverty line were more likely to experience [serious mental illness] SMI than those living at and above the poverty line (7.5 percent vs. 4.1 and 3.1 percent, respectively)" (The CBHSQ Report, 2016). Similarly, the World Health Organization (WHO, 2007) reported that individuals in poverty or low-income homes were eight times more likely to experience schizophrenia than their wealthier counterparts. Notwithstanding, the relationship between mental illness and lower income is complicated due to their bidirectional relationship (McSilver Institute for Poverty Policy and Research, 2019, May 20). That is, limited resources among those from lower SES groups may contribute to mental illness *and* mental illness may limit earning potential, contributing to poverty. Accordingly, the complexity of low SES calls for a multifaceted approach to meeting mental health needs. Nevertheless, a significant step may be focusing on increasing the quality of relationships and, by extension, potentially positive impacts on mental health.

An important factor of note is the barriers that low SES creates for seeking traditional counseling services. Although it is unknown to what extent enhancing the quality of life through the dialogical relationship e-learning modules would ultimately enhance mental health, the fact remains that alternative modalities are needed to meet the mental health needs of those in lower SES groups. Although there likely are many factors that influence the mental health of those in low-SES groups, there remains a clear need to develop accessible resources that can potentially enhance dialogical relationships and, perhaps, by extension, quality of life and the overall mental health of those in low-SES groups.

Purpose of the Study

The purpose of the current study was to evaluate the effectiveness of the dialogical relationship e-learning modules for increasing the relationship quality of individuals of low SES. Dialogical modules were created with the belief that, through the learning of qualities of the *I-Thou* relationships, individuals can create a greater quality of life regardless of SES. The goal of the study, therefore, was to increase the quality of relationships by teaching *presentness, directness, openness, and mutuality*— the four components of the dialogical relationship. Additionally, the study aimed to have a greater understanding of culturally appropriate ways (i.e., e-learning) to meet the mental health needs of individuals from low-SES groups. Further, this study aimed to serve individuals who may not benefit from services such as traditional counseling interventions and settings. In creating an intervention accessible to individuals of low SES, it potentially

benefited individuals without causing undue harm or stress, psychologically or financially, and focused the intervention on respecting and understanding clients' cultural beliefs and lens while not trying to pathologize or change it (Wang, Locke, & Chonody, 2013). The need, therefore, remains to continue developing effective and culturally appropriate interventions for low-SES groups.

Significance of the Study

In order to meet the needs of low-SES groups, the development of effective and culturally appropriate interventions was fundamental. The implementation of culturally sensitive interventions may be what contributes to better meeting the needs of a portion of this underserved population (Socioeconomic Status Office, 2019). Exploring the effectiveness of the dialogical relationship e-learning modules was an important step in potentially meeting this need within low-SES groups. People from low SES backgrounds have less access to traditional counseling (Sanchez-Page, 2005). Further, it is not uncommon for such clients to have negative experiences when they do present in a traditional counseling setting and experience interventions more appropriate to their wealthier counterparts (Wang, Locke, & Chonody, 2013). By examining the impact of the dialogical relationship e-learning modules on presentness, directness, openness, and mutuality, on relationship satisfaction and quality of life, counselors, supervisors, and counselor educators may better understand how to increase the quality of relationships among individuals of low SES. In order to increase our ability to reach individuals of low

SES, however, it was first vital to assess the appropriateness and efficacy of the dialogical relationship e-learning modules intervention.

Research Questions

1. What is the course of response of individuals of low SES self-reported presentness, directness, openness and mutuality, with participation in the four dialogical relationship e-learning modules?
2. To what degree are the four dialogical relationship e-learning modules efficacious for increasing relationship quality over time?
3. To what degree are the four dialogical relationship e-learning modules efficacious in increasing QoL over the course of the intervention?

Definition of Terms

Dialogical "refers to an approach based on the facts that we human beings are inherently relational; that we become fully human through relationship to others; that we have the capacity and urge to establish meaningful relations with others" (Mackewn, 1997, p. 81).

Presentness "... applies to attention, meaning that one actively attends to the speaker and continues to stay with him/her (sustaining attention)...Thus, the dialogic listener always attempts to go far beyond a mere physical presence to active involvement, interest, and attentiveness" (Floyd, 2010, p. 131).

Openness occurs when an individual is genuinely receptive to another person's being and receives others desire to be present (Friedman, 2002).

Directness "refers to the extent to which individuals talk directly about issues, express their opinions, and pursue their goal" (Guerrero, 2019, p. 4).

Mutuality "refers to the bidirectional movement of feelings, thoughts, and activity between persons in relationships, but its common usage is circumscribed by notions of social exchange" (Genero, Miller, Surrey, & Baldwin, 1992, p. 36).

I-Thou: Although Buber did not operationally define the *I-Thou* but rather described it, for the purpose of this study, *I-Thou* will be delimited as a relationship that is mutual between two completely present individuals who are aware of their separateness but choose to enter into the shared experience, *between* them, without losing grasp of themselves; a relationship stance where one gives of oneself and receives of the other from wholeness.

Quality of Life: Quality of life, for this study, was measured by the BBQ which considered six life areas to be important to overall QoL. Those six areas are, leisure time, view on life, creativity, learning, friends and friendship, and view of self (Lindner, Frykheden, Forsström, Andersson, Ljótsson, Hedman, Andersson, & Carlbring, 2016).

Socioeconomic Status (SES) "Socioeconomic status is the social standing or class of an individual or group. It is often measured as a combination of education, income and occupation" (American Psychological Association, n.d.).

Low SES: This study will be considered individuals who score 0 to 3 in the SES index 3 (See Appendix E) *for NCVS* which captures about 28% of the population (Berofsky, Smiley-Mcdonald, Moore, & Krebs, 2014).

E-Learning: “E-learning is an approach to teaching and learning, representing all or part of the educational model applied, that is based on the use of electronic media and devices as tools for improving access to training, communication and interaction and that facilitates the adoption of new ways of understanding and developing learning” (Sangra, Vlachopoulos, & Cabrera, 2012, p. 152).

CHAPTER II

REVIEW OF LITERATURE

Introduction to Chapter

This chapter considered the different factors that impact an individual's quality of life (QoL). Specifically, extensive literature exists on the nature of QoL and how social connections and relationship quality impact our mental health which, in turn, impacts the experience of QoL. Included in this chapter are considerations of the possible impact that teaching skills to enhance the relationship quality through the dialogical relationship e-learning modules (DREM) might have for those who receive such training. This chapter considered current theoretical framework and empirical studies that elaborate on the importance of teaching the dialogical relationship model and the impact it may have on the QoL of individuals who belong to a low socioeconomic status group. For one thing, teaching the DREM to individuals may have served to ameliorate loneliness and social isolation, at least in part.

Lack of Social Connection

The 'loneliness' epidemic (Health Resources and Services Administration) reports that loneliness and social isolation have increased through time, and currently, two out of five Americans report feeling lonely and socially isolated (HRSA, 2019). According to Larderi (2018), 46 percent of Americans reported feeling lonely "sometimes" or

"always." Additionally, about 43 percent of individuals reported feelings of deficit in the meaning of their relationship or the quality of their relationship. Understanding what contributes to loneliness and social isolation in the U.S., therefore, may provide insight into possible approaches to address this social concern.

In an international study (U.S., U.K., and Japan), more than two out of every ten people reported loneliness or social isolation in the U.K. and the U.S. (DiJulio, Hamel, Muñana, & Brodie, 2018). Also, throughout all three countries, individuals who reported loneliness were more likely to report despondency in either physical, mental, or economic contexts (DiJulio et al., 2018). Although loneliness and social isolation are two distinct constructs, they are commonly studied together. The connection between both constructs leads to the necessity of understanding them together while keeping aware of the nuanced differences. For instance, loneliness is the subjective experience of an individual's perceived deficits in social relationships or negative experiences due to negative social experiences. On the other hand, social isolation refers to the lack of social connection and structures that can be objectively measured (Beller & Wagner, 2018a). Further making understanding the nuances between the constructs important.

The closeness between constructs makes for each to be an influencing factor on the other Beller & Wagner, 2018a). Of import to mention is that while social isolation may influence experiences of loneliness, loneliness often can occur for individuals even when they are not socially isolated. Hereafter, with changes in the fabric of U.S. society (i.e., population demographics, generational culture shift), it becomes relevant to

understand how experiences of loneliness and social isolation may have a detrimental impact on health, specifically mental health.

Impacts of Loneliness and Social Isolation

Although loneliness and social isolation are distinct constructs, they are logically connected – a connection that has emerged empirically. Ge, Yap, Ong, and Heng (2017) explored loneliness and social isolation in combination in order to understand best what most poignantly contributes to depression. The researchers found a link between depression, social isolation, and loneliness, and individuals who experience social isolation report higher levels of depression and loneliness. Ge et al. (2017) found that poor social connectedness resulted in elevated depressive symptoms. Additionally, the researchers confirmed that social isolation and loneliness stand alone in their relationship with depressive symptoms (Ge et al., 2017), meaning that a relationship with depressive symptoms is visible even when an individual only experiences one (e.g., has work and friends network but has a subjective experience of lacking connection). Furthermore, the researchers found that loneliness has a stronger association with depressive symptoms than does social isolation. These findings suggest that for some individuals, experiencing social isolation may not result in experiencing loneliness and, by extension, carrying less of an influence in depressive symptoms than the individual who experiences the inverse (e.g., loneliness and not social isolation).

This may suggest that the subjective experience of loneliness is more salient than objectively being socially isolated. Beller and Wagner (2018b) summarized the impact of

loneliness as being most detrimental to mental health. These researchers also found, however, that social isolation most impacted cognitive and physical health. In a follow-up study, Beller and Wagner (2018a) aimed to understand further the impact on health by examining the effects of loneliness and social isolation on mortality, finding a synergistic interaction between loneliness and social isolation on mortality.

As some researchers have found, social isolation and loneliness continue to increase in our society, making further emphasis on the need for future scholarly focus (Ge et al., 2017). Some researchers, however, have found conflicting results about the relationship between loneliness and social isolation (Beller & Wagner, 2018b). Therefore, the need remains for further understanding of the nuances between loneliness and social isolation and the impacts on health. With these findings as well as the comorbidity between SES and loneliness, addressing relationship quality may be a crucial aspect of addressing QoL. Finally, current treatments exist that aim to decrease loneliness. However, it is necessary to note that by focusing primarily on increasing social networks and contact, we may not be decreasing depression and mental health concerns (Beller & Wagner, 2018a). Hence, a multifaceted approach to decreasing loneliness and depressive symptoms seems necessary (Beller & Wagner, 2018a).

Aliveness

On the opposite side of the spectrum of loneliness and social isolation is the experience of aliveness. Awareness of one's mortality is a central component of existential theory. A great contributor to this idea of living in the dichotomy of death was

Abraham Maslow. Maslow (as interviewed by Cleary & Shapiro, 1995) explored, from his personal experience, how life could sprout from becoming aware of death (something he called "borrowed time"- the time between his first heart attack and his fatal heart attack). Maslow postulated that in knowing mortality, we could become awakened to the beauty of the ordinary, an experience he named plateau experiences. Maslow believed that with time, we would understand better the ability to connect in a sustained manner to our daily experience in a way that was teachable and accessible to all individuals, regardless of their level of self-actualization. Similarly, Lerner (1986) explored the contrast needed in order to know emotional aliveness within the context of the absence of such aliveness. Both authors postulated the need for dichotomy (aliveness and deadness or absence of aliveness) in order for the experience of aliveness to emerge.

As stated in the previous chapter, aliveness is the experience of fully engaging with the world in our day-to-day life from a fully present and authentic *Self*. We experience our aliveness as a culmination of our "movements, feelings, reactions…" (Dellatonio, Innamatori, & Patore, 2012, p. 174). Joseph Campbell (1988) stated that, "what we're seeking is an experience of being alive so that our life experiences on the purely physical plane will have resonances with our own innermost being and reality, so that we actually feel the rapture of being alive." Campbell (1988) believed that as humans, we are looking beyond meaning to the experience of being alive.

With an increase in reported experiences of loneliness and social isolation within society, it may suggest the need for further understanding of aliveness and its cultivation. It is possible that both the need for cultivating aliveness is present and that the conditions

for the exploration of aliveness are accessible—perhaps as a result of the beginning ruptures of an era of societal abundance. Dr. Sean D. Kelly, professor of philosophy at Harvard University, explores the emergence of this era of exploration in The New York Times in his article Waking Up to the Gift of 'Aliveness' (2017). Kelly considered the patterns of life that, at times, can become lifeless, where routine and habit overtake inspiration and presentness. In his response to this phenomenon of lifelessness, Kelly postulated two possible ways to respond to this lifelessness. The first way of responding is to seek exciting and new opportunities – a response of following each impulse. He believed, however, inevitably this manner of responding to lead to despair once spontaneity and newness taper off or becomes unsustainable. The second way to respond is by making meaning (existentialist). Through making meaning, we find a reason for the routine, which creates a greater sense of life. Similar to Lerner (1986), Kelly examined the phenomenon of aliveness in its absence by understanding the matter that is lacking in our day-to-day life. Kelly believes that, in essence, when living the gift of aliveness, our lives capture the fullness of time (Kelly, 2017).

Lerner (1986) believed that an understanding of aliveness can only occur against the backdrop of emptiness (removing all other experiences). Lerner astutely observed that humans only come to know nothingness or emptiness when we have indeed experienced a time in life where we felt "emotional aliveness" (a contrasting paradox). Lerner captures this internal battle and paradoxical behaviors in the following way:

> One may feel compelled to flee from awareness of such experience [emotional aliveness] through hectic activities, the avoidance of being alone, eating, or

> drinking. While one unconscious strategy of dealing with emptiness is to attempt to keep the experience from emerging, another is an attempt to overcome the experience through other more intense ones, such as sadism, triumph, thrills, or power. Participation in inner experiences is the essence of living. Yet, tragically, one who suffers from a paucity of inner experiences may be aware only of a vague feeling of missing something. (p. 319)

In his above quote, Lerner is speaking of the dissonance that as humans we confront throughout life. He posits that experiencing dissonance is the catalyst to experiences of depression, anxiety, and mental illnesses. In essence, Lerner adds to the understanding of aliveness by capturing the antithesis of aliveness as a state of emptiness or deadness.

Through the absence of experiencing aliveness, individuals often experience going through the motions of life without a sense of presence and connection to the present. Tuominen (2010) stated that meanings are developed within their contrast. Understanding the contrast of deadness or sleepwalking gives meaning to aliveness. Esther Harding (1958) wrote of the experience of going through the motions as transactional interactions, something she posits as a state of emotional disconnection or sleepwalking through life. Harding opines that when an individual relates to the world and others without an emotional connection, they are, in this sense sleepwalking. Such disconnected interactions emerge unconsciously and as a defense mechanism.

Similarly, Lerner (1986) posited that a felt sense of nothingness (i.e., sleepwalking and disconnection) is often a defense mechanism, resulting from a lack of desire to feel the pain of not living as your actual or true self. The lack of confronting our mechanism of avoidance results in the individuals' experiences of nothingness. Lerner

(1986) duly noted that "the only path out of the paucity of inner experiences is to enter and face the inner dread. This process reestablishes one's connection with the aliveness of one's actual self" (p. 319). In essence, by reconnecting to ourselves, we become alive in a way that allows us to be present with others and within the world in which we live (Harding,1958; Lerner, 1986). Ultimately, aliveness fosters the idea that through connection, both with the self and others, humans can experience more fullness of life. An approach that helps foster relational connection and believes it is the right of all humans to connect relationally is Relational Cultural Theory (RCT).

Relational Cultural Theory (RCT)

Although the primary theoretical framework for the current study is the Dialogical Relationship Model (Friedman 2008), which will be discussed more fully below, the current study also is situated within the context of Relational Cultural Theory. Relational Cultural Theory (RCT) fundamentally asserts that as humans, our brains are wired for connection (Miller, 1976; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Trepal & Duffey, 2016). RCT approaches human growth from an underlying assumption that humans grow and develop through deep connection and mutuality in *growth fostering relationships*. Through this approach, a persons' ability to sort through relationships and have the skills for connection and mutuality is cultivated (Jordan et al., 1991; Miller, 1976; Trepal & Duffey, 2016). RCT redefines growth in a way that is culturally sensitive to how people respond to relational and cultural adversity. Further, RCT focuses on the impact of chronic disconnection and the impact it can have on people's lives – both

affecting the quality of interpersonal and intrapersonal relationships (Jordan, 2010). RCT also provides counselors with a context that facilitates discussion of multicultural and gender issues in a humanizing manner. Central to RCT is the depathologizing of client issues such as "issues of privilege, power, marginalization, stigmatization, belonging, and acceptance" (Duffey & Trepal, 2016, p. 379). RCT offers a self-in-relation model that postulates that humans grow in relation. Specifically, RCT identifies five qualities of growth fostering relationships: "sense of zest, empowerment, clarity, self-worth, and connection" (Duffey & Trepal, 2016, p. 379).

RCT operates under the assumption that humans are hardwired for connection (Trepal & Duffey, 2016). RCT also conceptualizes and brings into focus the societal promotion of disconnection by the stratification of people—recognizing the systemic problem of chronic disconnection at a societal level that is experienced by non-majority group members and marginalized individuals due to their lack of access (Duffey & Trepal, 2016). Central to this power and control dynamic is the role of majority group members in exerting their power over non-majority groups and marginalized individuals – to keep their power. Social sanction of these acts of discrimination leads to more significant disconnection at a personal level as well as society at large (Duffey & Trepal, 2016). Often, traditional counseling aims to mainly address the client's responsibility, which further perpetuates the oppression and narratives of majority groups (Duffey & Trepal, 2016). In counseling, a central component of RCT is accounting for societal components and the impact of disconnection on the individual. Specifically, RCT uses

the therapeutic relationship as a model for action in the client's relationships outside of counseling (Duffey & Trepal, 2016).

RCT posits that by altering our operating paradigm from one of self-sufficiency and individualism to a relational paradigm of achieving well-being and wellness through growth fostering relationships, we can bring about personal and social change (Trepal & Duffey, 2016). Of importance to note is the brain's signaling system for social exclusion and chronic disconnection. Both are coded and experienced the same as physical pain (Trepal & Duffey, 2016). As technology advances, sufficient confirmatory evidence of the importance of addressing the experiences of marginalized individuals and those who experience chronic disconnection grows. As Judy Jordan succinctly stated in her interview with Trepal and Duffey (2016), "There is a way in which many people dismiss the pain of marginalization, but marginalization is a huge barrier to social change and creates deep suffering" (p. 441). Most significantly, RCT magnifies how relational connectivity is a necessary condition for healing, which is similar to how critical connection is discussed in the dialogical relationship model.

Dialogical Relationship Model

While emotional healing may occur in different ways, the dialogical relationship model centers around the principle that healing occurs through the authentic connection between two individuals (Buber called it *the meeting*). This model fits within relational cultural theory and focuses more on how to create an authentic connection. Buber (1988) stated his belief that healing occurs through being made present by the other and, in this

awareness, we are present to them. By confirming the other, we can co-experience their reality and, in this way, validate and make the other present (Friedman, 2008). In other words, when we can embody the experience of another through "walking a mile in their shoes," we validate or confirm their personhood. When another embraces a person for their uniqueness, then the meeting can emerge in the between (Friedman, 2008). An essential component of embracing others is first to be authentic and a real person in our own right – this precedes any reality of the between (Friedman, 2008). Buber (1965) expanded on the ontology of the dialogical relationship by pointing out that both distance and independence is the precursor of a relationship—individuation is necessary for one to exist in a mutual relationship. Further, it is important to note that most relationships ebb and flow from an I-It (transactional) and I-Thou (experiencing being) relationship (Friedman, 2008). Succinctly, the dialogical relationship is in the between, where two real people genuinely experience each other and mutually confirm each other.

Presentness

Presentness speaks to the quality of being entirely absorbed by our subject, where our mind is not distracted or elsewhere (Wolvin, 2011). Kabat-Zinn (2015) spoke of presence as the energy field emergent of attention and intention. Sustained presentness takes practice and is a hard quality to develop (Kabat-Zinn, 2015). A related concept to presentness is awareness. It could be said that awareness is the meta-layer of presentness (sits one degree outside of moment to moment presentness). Awareness is being conscious of what and where one is (i.e., presentness) (Kabat-Zinn, 2016). Often,

however, we find ourselves tuned out of the present moment, which occurs habitually due to our unconscious patterns and programming (Kabat-Zinn, 2015).

Openness

Openness suggests genuineness from both individuals in a relationship that allows for each person to find their expression of their voice – perhaps in a way that was previously not possible. This openness brings with it an openness to others and oneself (Birrell & Freyd, 2006). Openness implies a transparent approach that allows for vulnerability (Jordan, 2010). For openness, we must wrestle with our images of perfection and the allowance of our vulnerability (Hartling, Rosen, Walker, & Jordan, 1986). One factor that may hinder the capacity of individuals to experience the dialogic in relationships is socioeconomic status.

Directness

While not as expanded as the other components in the dialogical relationship model, directness ties all of the components together. Directness contends that the quality of the communication which occurs within a dialogical relationship is based on authenticity. Hodges and Fowler (2010) identified directness as not only having a principle of direct and clear communication, but also posited that dialogue occurs within a safe space between the listener and the speaker. Therefore, this alludes to not only the rule-abidingness of speakers (i.e., waiting ones turn) but also the intention of the listener and the speaker is one of understanding each other through the exchanged communication.

Mutuality

The term mutuality refers to "the bidirectional movement of feelings, thoughts, and activity between persons in relationships, but its common usage is circumscribed by notions of social exchange" (Genero et al., 1992, p. 36). Additionally, mutuality is a mindset that considers the perspective of the other individual in the relationship – a sense of reciprocity (Skerrett, 2003, 2004). Central to growth fostering relationships is the responsiveness, transparency, and ability to present one's feelings and thoughts to others. Mutuality allows for the respect and boundary that is necessary for the conditions of vulnerability – one that is not taken advantage of by another (Jordan, 2010). Essentially, mutuality allows individuals to engage in growth fostering relationships that are relationships of love and connection. In this space, we allow others to impact us and permit them to see that they matter to us (Jordan, 2010).

Mutuality does not mean, however, equality or even sameness, which is apparent in relationships of parent to child or therapist to client. However, there is distinct equality in the value of the individuals involved in the relationship. In allowing for the de-armoring of ourselves, we invite others to do the same and enter a bi-directional space and relationship of mutuality (Miller, 2008). Through deeper caring, listening, and allowance for other's perspectives and worldview, we enter into the relationship of I-Thou or, in other words, mutuality (Birrell & Freyd, 2006). Mutuality and RCT call out the problem of a society and system that has become highly efficient yet emotionally hygienic to the point of disconnection. Jordan (1986) pointed to this needed social change from a paradigm that operates from a distance and objectivity to one where we permit

“affecting the other and being affected by the other” (p. 82), which she posits leads to the openness to influence, and overall emotional availability for one another.

Socioeconomic Status

Socioeconomic Status (SES) is measured by individuals’ "relationship to wealth, power, and prestige" (Encyclopedia of Diversity and Social Justice, 2014). Different from social class, SES takes into account an individual's occupation, education level, income, wealth, and cultural and political capital. Another term interchanged for SES is socioeconomic position (SEP). SES falls in three main groups, low, middle, and high. The delineation of SES groups varies in the literature and seem to be study-specific, limiting generalizability across research studies. The Encyclopedia of Diversity and Social Justice (2014) provides an overall, albeit conceptual, delineation of SES statuses. Accordingly, individuals of low SES are defined as those living around the poverty line who have little to no political and social capital. Individuals belonging to the middle SES group usually earn a livable income and may have completed some education or technical certifications. Individuals in the high SES group have family wealth, high income, and typically hold investments. Additionally, members of this group usually have achieved higher education levels and possess a significant amount of influence in society due to their social and political capital. Important to note is individuals in the high SES group usually exercise considerably more social and political capital. On the other hand, individuals belonging to the low-SES group often remain in low status due to lack of

access to wealth, income, and political power (Encyclopedia of Diversity and Social Justice, 2014).

SES can impact an individual's QoL which is mitigated by the access they have to different opportunities and privileges (American Psychological Association, 2017a). SES impacts the QoL throughout an individual's lifetime, physical health, and psychological health (American Psychology Association, 2017a). Of great importance is the understanding of the relationship between race, marginalized communities, and low SES. To close the gap of disparity and inequality in the United States, it is critical to understand the dynamics of our increasingly segmented society. According to the American Psychological Association (2017b), upward mobility becomes increasingly difficult among groups that experience discrimination and marginalization. Mobility is impacted further by the gap between individuals of low SES and their correspondents in middle and high SES. Minority groups are predominantly affected by the disparaging difference between SES groups and the disproportionate representation among groups of low SES in comparison to White Americans (American Psychology Association, 2017b). Therefore, the need for including SES in research is crucial to address the disparity gap (American Psychology Association, 2017a, 2017b).

SES and Health

Across several sectors in their lives, individuals of low SES continually experience more substantive disadvantages than those of higher SES groups. Specifically, relevant to this study is the impact individuals of low SES experience on their health and

mental health (Maisel & Karney, 2012). Individuals who struggle with financial strain and hardship experience increased mental health issues (Maisel & Karney, 2012). In a global study (including participants from 29 countries), Prag, Mills, and Wittek (2016) used participants' reports on their subjective SES as well as objective SES markers, and their self-reports of health. They found that after controlling for objective indicators of SES, individuals reported a positive correlation between their health and SES (Prag et al., 2016). Participants with higher income, occupation prestige, education level, and SES reported better health. Psychological well-being was reported highest in those with middle SES, and lowest in individuals in the low SES and high SES groups. Interestingly, these findings suggest a bell-curve effect with individuals falling in the middle of the SES spectrum reporting the highest levels of health, including mental health. Those in either extreme groups experience deterioration in their health, albeit likely for different reasons and circumstances.

Additionally, the term *subjective SES* (SSS) is used in the literature to capture a person's subjective perception of their position in society. Not surprisingly, perhaps, a persons' SSS also impacts their health, specifically their psychological well-being (Prag et al., 2016). Considering a person's subjective perception of being of lower SES is helpful in understanding outliers and communities that exhibit greater resilience. Süssenbach, Shäfer, and Euteneuer (2016) found support that an individual's SSS is a "causal factor for developing depressive thinking" (p. 23), particularly identifying that low SSS appears to foster depressive thinking and rumination.

SES and SSS are both predictors of different illnesses and overall quality of health. In a 32-year longitudinal study, Eloviano et al. (2017) found that ideal cardiovascular health was positively associated with higher SES. Individuals who had low SES in childhood but had a higher SES in adulthood were found to have improved heart health compared to those who remained in low SES (Eloviano et al., 2017). In another study on SEP and health, adolescents in the lowest SEP quintile reported low life satisfaction at levels significantly higher than other groups (Elgar et al., 2016). It seems, then, that overall health and mental health issues often are related to lower SES.

Other researchers have found similar results related to the relationship between SES (SEP) and psychological health and wellness. For example, Goldman, Glei, and Weinstein (2018) examined two studies of midlife adults in the U.S. to better understand the impact SES has on psychological health and wellness. Based on their review, they concluded that individuals belonging to low SES experience increasing hardship and decline in well-being compared to those in higher SES. Individuals of higher SES tended to demonstrate a slight decline in wellness and psychological health throughout their lifespan. In other words, little or no change is evident in individuals of higher SES while individuals of low SES experience deterioration of mental health due to stress factors. These findings suggest psychological health among American adults is increasingly stratified and represented unevenly across SES groups (Goldman et al., 2018).

SES and Quality of Life

SES also appears to be related to overall QoL. In a longitudinal study, Hegelund et al., (2017) followed 2079 infants in Denmark to understand the impact SES has on overall QoL. Participants were recruited from October 1959 to December 1961 with a follow-up from 2009 to 2011. QoL was measured by Satisfaction with Life Scale, Vitality Scale of the MOS-36 Item Short-Form Health Survey, and a questionnaire that included questions about QoL (e.g., "How is your quality of life at the moment?"). The researchers found that individuals of higher SES at infancy tended to stay at a higher SES in midlife and report higher scores on all three of the measures. These findings are particularly relevant, despite some limitations, due to their large sample and longitudinal design over the span of 50 years. Biederman et al. (2015) found similar findings on the positive relationship between SES and QoL, indicating the higher an individual's SES, the higher their reported QoL. Biederman et al. (2015) completed a study using structural equation modeling on 193 community-dwelling older adults in the Netherlands to understand QoL and SES. The researchers believed that due to the long life expectancy, retaining a QoL through life was crucial. Their study, therefore, focused on older adults. The study's results indicated that SES, social functioning, depression, and self-efficacy, have a significant effect on QoL. Relationships have also been found to significantly impact QoL (Maisel & Karney, 2012).

SES and Relationship Quality

Maisel and Karney (2012) reported increased mental health as related to higher reports of relationship quality. The researchers found that, while relationship quality was related to higher mental health, low SES had a moderating effect. In their study the demographics of the participants were 65.7% White, 11.4% Black/African American, 16.7% Latinx, and 6.1% reported Other. Although all individuals experience stress, individuals from low SES experience more significant stressors and have a decreased ability to protect their relationships from outside stressors. Thus, individuals of low SES report less relationship satisfaction (Maisel & Karney, 2012). For individuals in lower SES groups who experience stressful events, there is a higher chance of reporting a more significant impact of stress on QoL when compared to their counterparts from higher SES groups (Maisel & Karney, 2012). Deterioration of relationship functioning is augmented when individuals experience financial hardship or perceive having a financial strain. A compelling explanation of the link between relationship deterioration and low SES is the cost of mental health services which limits access to individuals from low SES (Maisel & Karney, 2012). When incorporating SSS, it makes sense that individuals who experience and are cognizant of financial stress and stressors would enact old behavior patterns and negative relationship dynamics (Maisel & Karney, 2012) without the financial resources to seek professional mental health services. This leaves the unanswered question about how counseling as a profession is effectively researching those traditionally underserved.

Counseling

As delineated by the American Counseling Association (Code of Ethics, 2014), counseling has the purpose of enhancing the development of humans across the lifespan, the celebration of diversity through a multicultural approach that values the uniqueness of people, social justice advocacy, and practicing ethically. Counselors, according to ACA, aim to promote "client growth and healthy relationships" (p. 3). Counseling, as defined in the 20/20 initiative and endorsed by 29 counseling organizations, "is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan, Tarvydas & Gladding, 2014, p. 368). Kaplan et al. (2014) addressed the criticism received from some organizations for not including a strong enough stance on social justice and multiculturalism.

Multiculturalism

Multiculturalism has been considered the "fourth force" in counseling, emerging and existing around the 1970s, as evidenced by increased attention in the scholarly literature (Pedersen, 1991). Pedersen (1991) posited that multiculturalism evolved to include a more "generic" perspective—expanding beyond only explaining the "exotic." Further, Pedersen (1991) points out the integration of multiculturalism throughout counseling as a framework of understanding individuals inclusive of their cultural identities. A notable shift in multiculturalism has been the expansion of the definition of *culture* to one that encompasses identifiers beyond nationality or ethnicity (i.e.,

demographic variables, status variables, and affiliations). Pedersen believed this shift in definition was a necessary evolution of the theory to account for the differences, not only between groups but within groups. He considered this broad definition of culture to be imperative to training new counselors moving forward in dealing with a pluralistic society with complex cultural identities (Pedersen, 1991), including variables related to socioeconomic status.

In the same special issue of the *Journal of Counseling and Development* that featured Pedersen's seminal article, Sue, Arrendondo, and McDavis (1991) shared a supportive view of the broadening of the definition of *culture* yet believed there were negative effects in acquiring this broader definition. For instance, the authors believed that broadening the definition can negatively impact visible minorities by a removed focus on issues they experience such as racism. Sue et al. (1991) ultimately explored the value of culture-specific approaches versus the benefits of broadening the definition of culture. Above all, their call to the ACA (then ACCD) was one of taking a bigger and more proactive role as a profession in increasing the integration of multiculturalism within the profession. A commitment they regarded be demonstrated through the incorporation of multiculturalism in education, research, and practice (Sue et al., 1991).

Almost 25 years later, Sue (2015) supported the need for bringing a social justice perspective to understanding clients' experiences and the study of harm to clients into potentially harmful treatments (PHT) research. Sue charged researchers of evidence-based practices (EBP) and PHT with the burden of said integration of a social justice perspective. A significant difference pointed out by Sue between multicultural counseling

(MCC) and other approaches (e.g., PHT) is the accounting of a broader psychosocial framework that includes systemic bias and discrimination that lead to harm of clients both individually and "groups, families, communities, systems, and society" (p. 362). MCC understands that all psychological interventions and ways of healing, by nature, are ethnocentric (Sue, 2015). Thus, MCC attempts to counter the ethnocentric influence of definitions of normality, diagnosis, and overall treatment protocols found within counseling at large. Sue powerfully called out the counseling profession to move beyond empty talks around multiculturalism all while continuing to practice, research, and train, mostly from a monocultural perspective. A need exists for PHTs, EBPs, and counseling research to include multiculturalism and social justice in a way that accounts for factors in client harm (e.g., cultural oppression). An important recognition made by MCC is that of meeting individuals and their needs in a manner that honors and empowers their culture.

One way to honor culture and operate from an empowering approach is to utilize community connections and rely on cultural strengths. For example, Dempsey, Butler, and Gaither (2016) aimed to understand how to meet the mental health needs of Black individuals through collaborating with Black churches. Such as suggested by Sue (2015), it is essential to acknowledge the limitations of EBPs in meeting the needs of groups that fall outside of their normed samples (e.g., white, middle SES). Black churches have served to fill in gaps in resources within the community by providing opportunities for training, space for social connection, and even functions as a recreation center for the community. Hence, historically churches within the African American community have

been a space of safety and advocacy that emerged to fulfill needs within the community (Dempsey et al., 2016). It is important that researchers recognize the importance of collaborating with members of the community and leadership within the culture and groups served. To develop an emic approach, therefore, it is necessary that interventions be developed with representative voices from within the group (Dempsey et al., 2016). Thus, collaborations with established community advocates (e.g., church, community centers) are imperative for counselors in meeting the needs of underserved communities. Ultimately, counseling professionals must recognize that multicultural competencies are ever evolving and that guidelines must keep growing to keep up with societal growth. That is, current understanding of society should influence counselors and their approach. This growing understanding is necessary when working with clients to meet their intersecting needs – to provide support in their well-being and overall mental health (Ratts et al., 2015).

Consequently, to capture the evolving understanding of culture and society, the current MCC guidelines were revised by the Association for Multicultural Counseling and Development (AMCD) in 2015. In revising the MCC guidelines, AMCD aimed to "... (a) reflect a more inclusive and broader understanding of culture and diversity that encompasses the intersection of identities and (b) to better address the expanding role of professional counselors to include individual counseling and social justice advocacy" (Ratts et al., 2015, p. 29). The authors provided guidelines that help counselors conceptualize clients by identifying the social construction of identities and acknowledging complexity of intersecting identities – going beyond the initial beliefs in

the body of literature in multicultural counseling. For this reason, continued revisions and critical thinking is necessary to provide diverse populations with culturally appropriate and ethical care.

To ethically meet the needs of diverse populations, counselors must approach clients from a "wide-angle lens," which incorporates the intersecting identities of clients and their social environment. Ratts et al. (2015) recommend using a socioecological model as a framework, where counselors collaborate with their clients to decide the best course of treatment. For instance, a socioecological model allows for treating the intrapersonal, interpersonal, institutional, community, and beyond (accounting for the many context individuals live in; Ratts et al., 2015). Considering clients' SES – which is a crucial component of their culture and identity – is an example of implementing the socioecological model.

Counseling and Low SES

In the context of multicultural and social justice counseling competencies, socioeconomic status is a needed cultural consideration. The experience of individuals of low SES creates different challenges in areas such as education, occupation, and overall health. In a world that is increasingly more connected, counselors must be aware of many contributing factors, including individuals who migrate from socioeconomically disadvantaged Nations (Nassar-McMillan et al., 2013). Foss-Kelly, Generali, and Kress (2017) highlighted the impact that poverty has on mental health and, by extension, the

counseling process. The authors postulated that counselors often are unaware of the negative impacts poverty can have on the counseling dynamic and progression.

All too frequently, counselors are unaware of SES as a cultural identity and the necessity to understand and incorporate considerations related to SES into their counseling approach. In response to this gap in counselors' effectiveness in working with clients of low SES, Foss-Kelly et al. (2017) proposed the I-CARE model. The I-CARE model aims to help counselors address their biases and incorporate the impacts of poverty in their client conceptualization – to aid in the removal of barriers for clients of low SES. The five components of the model are *internal reflect*, *cultivate relationship*, *acknowledges realities*, *removes barriers to growth*, and *expands on strengths* (Foss-Kelly et al., 2017).

A limited understanding of SES becomes a barrier for counselors to acknowledge and validate clients' SES experiences (Cook & Lawson, 2016). Cook and Lawson (2016) studied nine licensed professional counselors (LPC) in order to understand better counselors' awareness surrounding SES and social class. The researchers conducted a phenomenological (IPA) study and used in-person interviews. Salient in the findings was participants' misuse and simplification of the terms social class and SES. Often, participants conflated the definitions of the terms and carried assumptions related to both terms. All participants identified some ideas surrounding social class and SES, yet no participant was able to identify all three discrete factors composing SES (income, education, and occupation). Social class has a more extensive definition than simply SES. For instance, social class includes different facets of a person, such as how you raise your

children. SES is a component of social class, thus making the findings and suggestions of this study very relevant. While counselors in the study demonstrated an appropriate level of awareness of social class – based on the Social Class Consciousness Model – their limited understanding of social class and SES remained problematic (Cook & Lawson, 2016). Exacerbating the problem is that most counselors come from middle SES backgrounds while they mostly work with clients from lower SES than their own. In the researchers' own words, "...misunderstanding clients' cultural worldviews because they differ from those of the counselor can affect the counseling relationship negatively" (Cook & Lawson, 2016, p. 450).

Cook et al. (2019) conducted a 17-year systematic content analysis within two counseling journals and found that researchers continue to be limited in their inclusion of SES and social class in research. SES and social class were considered in 35% of the articles reviewed, most of which were empirical studies. Clark, Cook, Nair, and Wojcik (2018) completed a systematic analysis of ACA journals over the past 17 years related to inclusion of social class, analyzing 7,528 articles in ACA journals. They found only 37 articles that met the criteria (prioritization given to social class and related terms). Articles were excluded when only using social class and SES as demographic data. Out of the articles reviewed, only 9 focused on counseling practice and intervention This finding highlights the multicultural deficiency that often exists when working with individuals of different social class and SES than the counselor. While progress has been made in inclusion and diversity within the counseling field, much more is left to be done. The continued pattern of researchers dismissing social class and SES as a critical variable

is concerning, especially when considering the negative effects of poverty and, by extension, the impact that poverty has on the counseling process (Cook & Lawson, 2016).

The need remains to develop counseling interventions with social consciousness for individuals of low SES. Developing such interventions would allow providers to attend, ethically, to the needs of clients from different social class and SES; research must precede the development of these culturally inclusive interventions. The current reality of limited research in social class and SES signifies that counselors are potentially underserving and ineffectively working (perhaps even unethically working) with individuals of low SES (Clark et al., 2018). It is necessary then, that research continues in adapting and developing interventions for individuals of low SES (i.e., culture-specific).

Intervention Development

As the existing SES gap only increases between groups, the need exists for culture-specific interventions (Rodriguez et al., 2010). It is well documented that the current research on social class and SES is limited, thus reducing the amount of available culturally appropriate interventions for individuals of low SES. Accordingly, researchers need to bridge the gap between existing research and clinical practice. While there are several culturally adapted treatment models, one that uniquely focuses on the context and environment of individuals (e.g., social class and SES) is the Ecological Validity Model (Bernal et al., 1995; Bernal & Sanchez-Santiago, 2006). The Ecological Validity Model suggests eight areas to focus on when adapting or creating culture-specific interventions: language, persons, metaphors, content, concepts, goals, methods, and context. A strength

of this model is the focus on culture-specific validation of interventions. This model, therefore, accounts and conceptualizes the development or adaptation of interventions from within, for example, a specific socioeconomic context.

Researchers have considered social class and SES in systematic ways, albeit in a limited capacity. Boyd, Diamond, and Bourjolly (2006) focused on developing an effective intervention to support African American parents of low SES. The participants identified several essential components to effective treatment: 1) more psychoeducational programs, 2) a group setting that allows for connection among families of similar circumstances, 3) obtaining practical skills (e.g., computer skills), and 4) comfortable setting for the entire family. Participants listed schedules (parents' and childrens'), shame associated with seeking help, and balancing life demands as barriers to their success. Participants also identified that offering transportation, food, and childcare helped overcome some of the listed barriers (Boyd et al., 2006). Critically important to the current study was the finding of psychoeducational programs as a service to those of low SES. This, therefore, informed the intervention selected for this study, that of an online psychoeducational program developed to enhance relationship quality and, perhaps by extension, mental health, and QoL.

An important factor of The Ecological Validity Model is that it expands beyond solely *ecological validity*, moving from a procedural process (i.e., congruence with the environment from the participants' experience to the researchers' attributions of said experience) to increasing the external validity as a means of also increasing internal validity. An example of ecological validity is achieved through collaborative work

between research participants and researchers (e.g., incorporating participants' feedback throughout the intervention and in recommendations post-study; Bernal et al., 1995). Through the process of collaboration, the Ecological Validity Model develops or adapts interventions in a culturally sensitive manner.

Bernal (2006) further expands its framework (see Bernal et al., 1995) for the development of culturally sensitive interventions through research. The first stage of an intervention development is divided into two phases. Phase 1a establishes the mechanism of change posited by the developers of the intervention or adaptation (i.e. how is the intervention assumed to effect change?). Phase 1b focuses on the development of procedure, treatment manual, and an initial study that explores the effectiveness of the intervention among a small sample (less than 10 participants; Bernal, 2006). The entirety of Phase 1 focuses on establishing a treatment procedure that serves as the groundwork for a more extensive pilot study to examine the effectiveness of the intervention and the creation or adaptation of the treatment manual (Bernal, 2006). A noteworthy reminder is that the development of an intervention is part of a broader research agenda. The current study, therefore, aimed to establish this first phase.

Summary and Recommendations

Ultimately, individuals of low SES require the development of counseling interventions and services tailored to their specific needs. This literature review explored loneliness, social isolation, aliveness, relational cultural theory, dialogical relationship model, socioeconomic status, SES and health, SES and QoL, SES and relationship

quality, counseling, multiculturalism, counseling and low SES, and the development of an intervention. Taken together, this built an argument for specific consideration to interventions that are uniquely tailored to consumers from lower SES groups.

As highlighted by Bernal (2006), the development of an intervention or the adaptation of an existing intervention for a specific cultural group is to be considered a process (composed of several steps). In agreement with recommendations for developing interventions (Bernal, 2006), this chapter focused on the first phase of the development, an outline of the theoretical components of the intervention. This study attempted to take the first step in developing a culturally appropriate intervention for individuals of low SES in improving their overall relationship quality.

CHAPTER III

METHODOLOGY

Methodology

As discussed in the previous chapter, it is important to include socioeconomic status into counselors' understanding of clients and intervention selection. Meeting the needs of individuals of low SES starts with incorporating their worldview into research, specifically, in the development of culturally appropriate interventions (Clark, Cook, Nair, & Wojick, 2018). It is important to meet individual's culture-specific needs. For example, individuals of low SES may struggle with childcare and transportation, making traditional counseling difficult, if not totally out of reach. Therefore, an intervention was developed with these specific needs in mind in hopes to develop an alternative to traditional counseling interventions.

Researchers have demonstrated that individuals of low SES struggle with greater barriers in their relationships. In other words, stressors due to low SES create greater distress among couples and individuals of low SES than their counterparts of higher SES (Maisel & Karney, 2012). Relationship quality is essential to mental health; therefore, with a growing gap between SES groups, the development of culture-specific interventions remains (Rodriguez et al., 2010).

The purpose of the current study was to explore the effectiveness of a brief dialogical relationship e-learning modules intervention in increasing relationship

satisfaction and quality of life. This study was designed to enhance relationship quality through a culturally sensitive approach for individuals of low SES. This study adds to the literature on effective interventions for individuals of low SES and provided direction for future intervention development and adaptations. In order to evaluate the effectiveness of this intervention, I used Single Case Research Design methodology, which examined change within a small group. According to Bernal (2006), this is the first phase to developing culturally-appropriate interventions. In this chapter, I will describe the rationale for Single Case Research Design, research questions, selection of participants, instruments, procedures, data analysis, and *a priori* limitations.

Single Case Research Design

Often, in counseling, single case research design (SCRD) has been avoided. Ray (2014) suggested, however, that a lack of training in implementation and SCRD analyses are the potential reasons counseling researchers underuse this methodology. In this study, I used SCRD, which fits the exploratory nature of this study of a brief psychoeducation for individuals of low SES – individuals who are underserved and understudied. One of the main purposes of SCRDs is determining if a causal relationship exists such that an intervention effects change in constructs of importance (Kratochwill et al., 2010). In this study, the researcher sought to determine whether or not a series of psychoeducation modules on dialogical relationship would effect change in relationship quality and quality of life.

Continued emphasis on evidence-based practice confronts counselors, with the need to implement research into their practice; SCRDs are an effective and feasible manner to produce such casual inferences between intervention and desired outcomes (Lenz, 2015). Lenz (2015) suggested that SCRDs provide counselors with the opportunity to examine the efficacy of an intervention, as well as provide evidentiary support, while still capturing the voices of those participants who are historically understudied.

SCRDs entail manipulating the independent variable – which is the focus of this research design - with an ability to make inferences between treatment and effectiveness (Ray, 2014). A key value of SCRD is the researcher's ability to denote the conditions in which participants do respond to a treatment and when they do not, which may be lost in larger studies such as between-group comparisons (Kratochwill et al., 2010).

Although A-B designs are central to SCRD designs, threats to internal validity based on history are problematic and, therefore, the A-B-A design is preferred (Ray, 2014). A-B-A designs strengthen the conclusions of interventions but have yielded limited replicability (Ray, 2014). Ray (2014), however, supported the use of A-B in highlighting the difficulty of using an A-B-A and A-B-A-B or other SCRDs due to the complicated entanglement of carryover effects — what phase is contributing to the changes in symptoms? For this study, it was important to acknowledge the limitations of an A-B-A-B SCRDs due to the psychoeducational nature of the intervention possibly having carryover effects. Gallo et al. (2013) suggested that A-B designs offer valuable insight in cases where other SCRDs are not a better fit (i.e., A-B-A-B) such as in the case

of psychoeducation interventions due to possible carryover effects. Hitchcock et al. (2015) supported A-B and A-B-A SCRDs as valuable contributions within applied fields (Kratochwill et al., 2010). Accordingly, an A-B-A design was used in this study.

Ray (2014) elaborated on the appropriateness and usefulness of SCRDs in the field of counseling:

> In the field of counseling, replicated withdrawal/reversal designs are problematic in implementation. During the B phase, a counseling intervention is introduced. Typically, the goal of a counseling intervention is to have a lasting effect, such as clients experiencing fewer symptoms of depression because they feel accepted and understood, or clients learning to identify the effect of thought on emotions and behaviors. Hence, theoretically, when the intervention is withdrawn, the client is likely to continue to show improvement. When the intervention is introduced once again (i.e., A-B-A-B), it would be difficult to discern if improvement is due to the first B intervention, personal reflection during the withdrawal of the A phase, or the second B intervention, and so on. (p. 396)

SCRDs have seven steps recommended by Ray (2014) to follow in the development and completion of a study. Step 1 is to define research questions. Step 2 is to identify the participants and the inclusion criteria. Step 3 is to choose measurements and assessments. Step 4 defines the intervention. Step 5 involves selecting the SCRD (e.g. A-B). Step 6 involves establishing the baseline. Step 7 implements a phase protocol with measuring at multiple observation points. Step 8 completes the process by analyzing the data and interpreting.

Research Questions

1. What is the course of response of individuals of low SES self-reported *presentness, directness, openness* and *mutuality,* with participation in the four dialogical relationship e-learning modules?
2. To what degree are the four dialogical relationship e-learning modules efficacious for increasing relationship quality over time?
3. To what degree are the four dialogical relationship e-learning modules efficacious in increasing QoL over the course of the intervention?

Participants

Inclusion Criteria

To better serve individuals of low SES in counseling, participants in this study were individuals who self-identified as low SES and wanted to benefit from psychoeducation on dialogical relationships. To participate in this study, individuals must have identified as having at least one intimate or close relationship. Intimate or close relationships may include familial, friendship, or romantic relationships. Participants who identified as having an intimate or close relationship were an appropriate population for this study, as the purpose of this investigation was to understand the impact on relationship quality and QoL of this intervention with individuals of low SES. According to Cook and Lawson (2016), a person's socioeconomic status is part of their culture and, therefore, focusing this study on this cultural group –individuals of low SES – was appropriate and sufficiently focused.

For the purpose of this study, participants met the following criteria: (a) self-identify as low SES; (b) be at least 18 years of age or older; (c) speak English; (d) have reasonably easy access to the internet to allow them to participate fully in the intervention; (e) meet the cut offs of low SES based on occupation, income, and education as outlined by the *Bureau of Justice Statistics U.S. Department of Justic*e; (f) be free of any current suicidal ideation or severe mental health issues that might potentially impact their ability to participate in the study; and (g) self-identify as being in an at least one intimate or close relationship.

Participants were required to access the online intervention and handouts, so internet access was necessary. To reduce barriers, however, participants were asked to choose how they would like to receive their modules (i.e., video lesson, handout, and assessments). Options were offered in order to meet the needs of the population and to avoid the assumption that all individuals have equal access to technology and type of technology. Choices included Canvas and email message with daily reminders via text. Regarding (e), SES index 3 was used to determine low SES. Participants who scored between 0-3 of index 3 of the Bureau of Justice Statistics U.S. Department of Justice were considered within low SES (See Appendix E).

Sampling Method

The researcher took reasonable precautions by screening for any moderate to acute depression in accordance to the ACA guidelines (ACA, 2014, G.1.e.). Researcher also sought approval of IRB. Although the requirement for implementing SCRDs is a

case of one, many researchers use three cases to account for the possibility of attrition (Lenz, 2015). Eleven participants initially demonstrated an interest in the study, and five participants completed the entire study. The inclusion of more participants allowed the researcher to incorporate more diversity to create a better understanding of under what conditions the intervention was and was not effective. Participants who met the inclusion criteria were formally invited on a first-come basis. Participants who were interested completed the dialogical relationship e-learning modules and completed assessments pre-intervention, during intervention, and post-intervention.

Participants were recruited through purposive sampling to reach the specific population of this study. The combination of purposive, volunteer, and snowball sampling were used to obtain the number of participants for this study with an exclusion criterion that no participants were included who were considered as a partner of another participant. Prospective participants who reached out and expressed interest were screened for inclusion criteria and invited to a phone pre-intervention interview to explain the study and to ensure no harm was done through the study.

Recruitment Strategy

The researcher obtained permission to distribute recruitment information through local community centers and agencies (e.g., Mental Health Associations), which were contacted and provided with a promotional package for the dialogical relationship e-learning modules. The package included a recruitment flyer and online material to be posted on their local websites. Individuals who responded with interest were contacted

via phone for a 15-minute screening call to introduce the study and respond to any questions potential participants had.

Instrumentation

Demographic Questionnaire

The participants completed a demographic questionnaire (See Appendix F). Participants completed a section on their SES including income, occupation, and education level. In addition, race, age, ethnicity, relationship status, and occupational status were collected. The responses in the sociodemographic section were used to establish inclusion criteria.

Dialogical Relationship

A 9-item questionnaire was developed to answer question 1. Due to the time repeated data collection points, a 9-item questionnaire was developed instead of the use of existing assessments. Additionally, all existing measures reviewed by the researcher were lengthy and did not directly measure the dialogical relationship constructs included in this study. An example of an item in the questionnaire is "To what extent are the dialogical relationship e-learning modules achieving the intended outcomes in mutuality, in the short, medium, and long term (See Appendix G)?" Additionally, participants self-reported on videos completed during each assessment.

Relationship Satisfaction

The 7-item Relationship Assessment Scale (RAS; Hendrick, 1988) was used to measure quality of relationship amongst participants and their significant relationships. This measure was intended for use with a broader definition of close relationships—expanded beyond solely romantic relationships. Hendrix (1988) suggested that with minimal changes to the language, this relationship assessment could be adapted to measure friendships (See Hendrick, Dicke, & Hendrick, 1998). Hendrick et al. (1998) updated the language from *partner* to *mate* and *marriage* to *relationship*. Further, to make the measurement broader and more inclusive, they compared the RAS to other measures with more diverse samples and found the measure to be a good option for assessing relationship satisfaction.

In their study, Hendrick (1988) reported an internal consistency of .86. This assessment was designed and has been used in a wide range of studies from intimate partners to relationship between therapist and client (Carriere & Kluck, 2013; Larson, Vatter, Galbraith, Holman, & Stahman, 2007; Guldner & Swensen, 1995). This measure was normed on individuals of higher SES (i.e., college students) but later was compared to other measures normed with more diverse samples (Hendrick et al., 1998). Additionally, due to its validity and comparableness with the longer Dyadic Adjustment Scale – which has been found to have sound psychometrics – (Hendrick, 1988), the RAS was selected for this study. The scale is written at a third-grade reading level, test-retest reliability has been reported .85, and reported inter-item reliability is .49 with an alpha of .89 (Hendrick et al., 1998). To account for participant fatigue, given that participants

completed the assessments multiple times, keeping assessments brief was key. Therefore, RAS was a great fit for this study since it was developed as a short assessment for this purpose. In addition, RAS has been demonstrated to hold good psychometrics.

Quality of Life

The 12-item Brunnsviken Brief Quality of life scale (BBQ; Lindner et al., 2016) was used as an overall measure of QoL. Lindner et al. (2016) reported an intra-class correlation coefficient of .82 (95% CI: .75–.89), which indicates high test-retest reliability. The BBQ was designed to be user friendly, easily administered, free, and reliable in measuring QoL in both clinical and non-clinical samples. Good internal and test-retest reliability were reported, while the Cronbach's alpha measure of internal consistency has been previously reported at .76. Scales with few items are reported to often have a lower internal consistency but the authors found the .76 to be within the appropriate range for social science constructs (Lindner et al., 2016).

The scale was administered by asking participants to circle the answer that best reflected the participants' experience. Higher scores indicated a higher QoL. An example of an item on the BBQ is "I am satisfied with my leisure time: I have the opportunity to do what I want in order to relax and enjoy myself" (Lindner et al., 2016).

Procedures

The researcher designed a data collection schedule including the duration time of each phase and what the phases included. All data collected was maintained in a secure cloud, BOX, to ensure confidentiality of information. Surveys were collected through

Qualtrics in order to ensure the safety of the data. Further, for confidentiality of the participants, all participants names were changed to mask their identity. Names of participants will be kept up to five years in a password protected computer only accessed by the researcher. There were five phases to this study, specifically, preparation phase, recruitment and screening phase, pre-intervention phase, intervention phase, and postintervention phase.

Preparation

During the preparation phase, the researcher reviewed the literature and developed the dialogical relationship e-learning modules, module handout, and composed instructional messaging for participants during each phase of the study (i.e., instructions to complete assessment for each data collection point).

Recruitment and Screening Phase

During this phase, the researcher contacted regional mental health associations and community agencies for collaboration possibilities and local libraries. Additionally, an online study recruitment flyer was distributed through Facebook. Participants who responded to the recruitment flyer (See Appendix A) were screened for eligibility through a phone screening questionnaire completed by the researcher (See Appendix B). Eligible participants received the informed consent form for this study via email and had an opportunity to ask questions about the information included in the consent form via phone call with the researcher. In the informed consent form emailed to participants, information on the nature of the intervention, confidentiality, data collection practice was

included. Participants were asked to verbally consent to research that allowed for the researcher to collect their data (See Appendix C). Followed, the initial questionnaire and demographic questionnaire were completed upon receiving consent from each participant.

Pre-intervention

In the pre-intervention phase, participants were invited to participate and given a 15 to 30 minute phone call with the researcher to address procedural questions. Participants were asked to choose which format of receiving the dialogical relationship e-learning modules they preferred (e.g., Canvas, email). Participants completed three baseline time points prior to receiving their first dialogical relationship e-learning module. All participants who completed the pre-screening documents and completed the pre-intervention assessments (total of three) received a $15 Visa gift card.

Intervention

Every day participants completed assessments. Modules were delivered to participants starting on day four and then every consecutive day, for the next three modules. Participants were reminded to consider materials within only one intimate or close relationship they identified. In the intervention phase, participants completed assessments at the completion of each module. Videos were uploaded to YouTube on a private channel only accessible to participants. Instructions for each module were delivered through direct messaging and Canvas. All participants who completed the modules and assessments (total of four; $10 each) received a $40 Visa gift card.

Postintervention

After completing the baseline phase and intervention phase, participants completed three postintervention data collection points. In the postintervention phase, participants completed assessments daily, totaling a 10-day length of study time (See Appendix D). All participants who completed the postintervention assessments (total of three) received a $25 Visa gift card.

Table 2

Data Collection and Intervention Schedule

Day	**Tracking**
1	Baseline 1
2	Baseline 2
3	Baseline 3
4	Module 1 & Time 1
5	Module 2 & Time 2
6	Module 3 & Time 3
7	Module 4 & Time 4
8	Postintervention 1
9	Postintervention 2
10	Postintervention 3

Research Setting

It was paramount to consider the impact of structural barriers to low-SES groups in order to meet the needs of this population. Some of these structural barriers to

accessing mental health services are rural areas, lacking health insurance, financial and life strains, and mental health stigma among individuals from low SES groups (Fiscella et al., 2000; Thoits, 2005). Usoro and Abid (2008) considered e-learning an effective way to address barriers of time, distance, and socioeconomic status.

In considering these factors, the e-learning and online forum offered an appropriate research setting (Chang, 2005). Further, the low-cost of an e-learning intervention permits for replicability and feasibility for future implementation. It is important to note that built into the e-learning modality is a social justice component of education and wellness being suited for all humans and not just exclusively to individuals in higher SES groups who have the privilege of receiving professional counseling or other services (Stracke, 2019).

Social justice and multicultural counseling is a necessary lens to take in the development of culturally appropriate interventions. Accordingly, the current study aimed to develop and implement a brief e-learning psychoeducation intervention. As a comparable example, Rogers, Schneider, Gai, Gorday, and Joiner (2018) identified brief web-based psychoeducation interventions as an effective treatment for decreasing stigma surrounding mental health. Namely, the authors identified brief web-based psychoeducation interventions as effective in addressing barriers to treatment such as cost-efficiency. In a similar study, Miller-Graff, Cummings, and Bergman (2016) studied the effects of a four-session psychoeducation intervention aimed to decrease conflict between parent and children. These researchers found a significant main effect on the two

groups that received treatment (i.e., not in the control group) in constructive and destructive conflict behaviors.

Psychoeducation is among the most effective of the evidence-based practices that have emerged in both clinical trials and community settings. Because of the flexibility of the model, which incorporates both illness-specific information and tools for managing related circumstances, psychoeducation has broad potential for many forms of illnesses and varied life challenges (Chang, 2005; Usoro & Abid, 2008).

Data Analysis

Visual analysis was completed after data collection was completed and percentage non-overlapping method was utilized to measure effect size (Lenz, 2013; Ray, 2014). Four key components were examined, the predictable baseline pattern, examination of the data within each phase, comparison between the phases to assess the impact of the intervention and integrating all the data to determine demonstrations of effect (Kratochwill et al., 2010). Results were included per case study and evaluated for their consistency through the three phases of the study (baseline, treatment, postintervention).

Trustworthiness

Lenz (2015) posited that SCRDs is a trustworthy and practical option for practitioners. To ensure trustworthiness, however, he suggested a minimum of three baseline data collections. Therefore, a three-point baseline was established prior to introducing the intervention (i.e. A-B-A; Kratochwill et al., 2010). Ultimately, in counseling research ethical considerations must be taken to guide the best research design

that allows for trustworthiness while preserving the focus on the participants' well-being (Lenz, 2015).

A Priori Limitations

Limitations existed in this study due to the brief length of the intervention. Due to the different platforms (i.e., Canvas, email) of e-learning distribution, the researcher relied on the participants' self-reporting on the completion of each module. The researcher, therefore, could not verify if participants engaged with or watched videos. Additionally, the limited baseline data collection made for data stabilization potentially to not be present, or, as well established as desired. The brief nature of the current study limited the information available regarding long-term effects of the training.

Pilot Study

The researcher conducted a pilot study to test the content and order of psychoeducation modules. The pilot study aimed to solicit feedback to strengthen the psychoeducation modules by increasing clarity and removing confusing content. The reviewers considered the content for appropriateness, clarity, and language level. Four content experts were invited to participate, with three providing their feedback. Two reviewers were doctoral counseling students and one was a counseling practitioner.

Feedback from Content Experts

Feedback covered the pace of content, review of clarity of the modules, the order of modules, and an opportunity to provide overall feedback. Generally, there was

consensus regarding the clarity of content. One reviewer made suggestions on some editorial components to make a more uniform product, such as providing the same overview slide at the beginning of each module. Further, they recommended some changes around possible jargon language. The second reviewer provided specific editorial feedback such as transitions (i.e., cutting or long pauses for greater smoothness). Additionally, they suggested a few areas for review in which they felt the material was too congested. The third reviewer provided no feedback that warranted changes to the modules but highlighted that the modules were well organized and had a natural flow.

Changes to Full Study

Feedback provided the impetus for editorial changes to the psychoeducation modules. The first change was to reduce material where feedback suggested there was too much information in a given module. Further, the researcher edited transitions between speaking segments for smoothness. Jargon used in videos was simplified by adding additional slides with definitions and examples. It seems important to note that, while changes and feedback on the visual product were pivotal in making the finished product stronger, all three reviewers agreed that content was explicit and met the aim of the specific module. Most changes were around jargon, definitions, and transitions between talking segments in videos.

Summary

The purpose of Chapter One was to provide an overview and rationale for the current study. In Chapter Two, socioeconomic status, mental health, multicultural

counseling, and related literature was reviewed, integrated, and synthesized. In the current chapter, the researcher established the methodology, rationale, and procedures for the current study.

CHAPTER IV

RESULTS

In Chapter 1, the researcher introduced the current study by considering the purpose and significance of this study. In Chapter 2, the researcher provided a review of the literature with a particular emphasis on the impacts of socioeconomic status on relationship quality and, by extension, quality of life (QoL), focusing particularly on gaps in the existing literature surrounding efficacious treatment modalities for individuals of low SES. The researcher highlighted research and scholarly writings on the relatively ineffective course of treatment of persons from low SES households and how middle SES normed counseling approaches may have detrimental effects on individuals from low SES households (Cook & Lawson, 2016). Finally, the rationale for the development of the dialogical relationship e-learning modules intervention was described. In Chapter 3, the researcher outlined the single case research design (SCRD) as the methodology and described hypotheses, instrumentation, data analyses, a priori limitations, and results of the pilot study. In this chapter, the researcher reports the findings of the analyses organized in response to the three research questions. Results are included per case study and evaluated for their consistency through the three phases of the study (baseline, treatment, postintervention). Hott, Limberg, Ohrt, and Schmit (2015) delineated the use of visual interpretation as the primary interpretation but also suggest a determination of

effect. The analyses include social validity and are addressed in summary in this chapter and discussed at greater length in Chapter 5.

Research Questions

The study followed the following research questions:

1. What is the course of response of individuals of low SES self-reported presentness, directness, openness and mutuality, with participation in the four dialogical relationship e-learning modules?
2. To what degree are the four dialogical relationship e-learning modules efficacious for increasing relationship quality over time?
3. To what degree are the four dialogical relationship e-learning modules efficacious in increasing QoL over the course of the intervention?

Results of Analysis

The findings are described in this section in order of the three research questions, organized by case as is consistent with a case study. That is, it is the experience of the individual over time that is of interest rather than aggregating the data across participants. Of equal importance is providing the context of the data collection process to foster procedural integrity (Hott et al., 2015). The researcher maintained the same protocol with each participant for screening, initial email, follow-up emails, and utilized a duplication system to ensure fidelity to survey content, as well as used the same intervention for each participant on Canvas (delivering platform) with the corresponding links and messages. Additionally, the researcher used a journal to document any communication between

researcher and participant or changes due to any issues that arose over the course of the intervention.

The researcher implemented an A-B-A SCRD to examine the degree of treatment effect associated with the dialogical relationship e-learning modules intervention among adults from low SES households. The design was selected given the exploratory nature of the present study, the ability to identify treatment effect for individual participants, and as the first phase to developing culturally appropriate interventions (Bernal, 2006).

Participants

To determine if participants met inclusion criteria, an initial screening was offered to individuals who expressed their interest and belonged to a household with approximately $30,000 collective annual income or less, to determine if they met inclusion criteria. Additionally, the researcher aimed to reach individuals who suggested interest in improving an intimate or close relationship by completing the psychoeducation on dialogical relationships. Participants who reached out or provided their contact information were contacted for an initial screening call. The researcher screened for the following criteria: (a) be at least 18 years of age or older; (b) speak English; (c) have reasonably easy access to the internet to allow them to participate fully in the intervention; (d) meet the cut-offs of low SES based on occupation, income, and education as outlined by the Bureau of Justice Statistics U.S. Department of Justice; (e) be free of any current suicidal ideation or severe mental health issues that might potentially impact their ability to participate in the study; and (f) self-identify as being in

at least one intimate or close relationship. Regarding (d), SES index three was used to consider low SES. The calculations included annual income, level of education, and number of members in the household. Participants who scored between 0-3 of Index 3 of the Bureau of Justice Statistics U.S. Department of Justice were considered within low SES and eligible for participation in this study (See Appendix E).

Eleven participants expressed interest in participating in the study; the first participant met all criteria but did not meet inclusion criteria based on annual income. A second participant did not have access to reliable internet. A third and fourth participant went through setting up their respective initial phone call screening but did not respond to phone calls and were not pursued further. A fifth and sixth participant qualified, completed the screening, and began the study. However, one provided invalid data noted by a quality question regarding having watched modules, and the other did not complete their surveys within the daily window. This left five participants who remained and completed the study. All the participants were women. Four identified as Latina, and one as African American. Two of the participants identified as single and never married, one as divorced, and two as married. All participants reported feeling physically safe within their intimate relationships, yet one participant reported feeling emotionally unsafe with members of her family. All participants were screened for suicidal ideation, and all reported having no current suicidal ideation. The researcher used pseudonyms to report the data to protect the identity of the participants.

Participant 1 Mariana speaks fluent English, is of Latino ethnicity, had access to the internet, and identified as being in at least one intimate or close relationship. With her

included, her household consists of four individuals who earn approximately $29,000 annually as a collective. Mariana completed some high school, attending as far as the tenth grade. She reported having no SI and did not identify any diagnosis of mental illness. Additionally, she reported feeling safe within her intimate or close relationship. Mariana fell in the 25-34 age bracket, had been unemployed outside of the house over the last six months, and was married at the time of participation.

Participant 2 Esmeralda speaks fluent English, is of Latino ethnicity, had access to the internet, and identified as being in at least one intimate or close relationship. With her included, her household consisted of four individuals who earn between $20,000 and $28,000 annually as a collective. Esmeralda completed some college but did not earn a degree. She reported having no SI and no mental illness. Additionally, she reported feeling safe within her intimate or close relationship. Esmeralda fell in the 18-24 age bracket, had been employed as a technician or associate professional over the last six months, and was single and never married at the point of participation in the study.

Participant 3 Viviana speaks fluent English, is of Latino ethnicity, had access to the internet, and identified as being in at least one intimate or close relationship. With her included, her household consisted of three individuals who earn between $25,000 and $30,000 annually as a collective. Viviana completed her four-year higher education coursework and earned a Bachelor's degree. She reported having no SI and no mental illness. Additionally, Viviana reported feeling physically safe, but having some emotional unsafety within her extended familial relationships. She fell in the 35-44 age bracket, had

worked in a clerical position over the past six months, and was single and never married at the time of participation in the study.

Participant 4 Carmen speaks fluent English, is of Latino ethnicity, had access to the internet, and identified as being in at least one intimate or close relationship. With her included, her household consisted of two individuals who earn approximately $14,000 annually as a collective. Carmen completed her community college higher education coursework and earned an Associate's degree. She reported having no SI and having a diagnosis of General Depression. Additionally, she reported feeling safe within her intimate or close relationship. She fell in the 45-54 age bracket, had been unemployed outside of the house for at least the past six months due to a reported disability, and was divorced at the time of participation in the study.

Participant 5 Cadence speaks fluent English, is of African American ethnicity, had access to the internet, and identified as being in at least one intimate or close relationship. With her included, her household consisted of two individuals who earn approximately $18,000 annually as a collective. Cadence completed her four-year higher education coursework and earned a Bachelor's degree. She reported having no SI and did not indicate any diagnosis of mental illness. Additionally, she reported feeling safe within her intimate or close relationship. She fell in the 55-64 age bracket, had been self-employed over the past six months, and was married at the time of participation in the study.

Context of the Study

During the study, all participants remained in daily contact with the researcher. As the researcher's academic committee suggested using multiple communication strategies, participants expressed a preference for two different strategies, e-mail and the Canvas platform. Participants 1, 2, and 3 all began with using Canvas to receive messages, announcements, personalized survey links, videos, and handouts. Unfortunately, however, all three participants experienced some difficulty with this platform, so the researcher moved to direct messaging via email. Direct messaging resulted in no further complications or delays. Participants 4 and 5 began after this initial glitch and completed the study solely through direct messages via email. Daily emails were composed to all participants. Additionally, text messages were sent to each participant in the morning as a notice of the email they were sent. Each day, a reminder was sent to participants who had not completed their respective survey by 9 pm.

Intervention and Fidelity

The researcher selected an online intervention, as recommended by Stracke (2019), to meet access barriers for a low SES population. Overall, culturally appropriate interventions can be increased by technology, which allow for opportunities to have participants from different geographical locations complete the study. This is aligned with other uses of online forums, which have been suggested to be effective at increasing the reach of traditionally underserved individuals (Chang, 2005). The intervention consisted of an approximately 6-minute psychoeducation video on each of the four core

components of dialogical relationships. The videos were shared daily, one per day in the same order for each participant, with a corresponding handout for review. The handout covered the main takeaway points, potential applications, and exercises for practice. The content of each video and all interactions with participants were developed by the researcher.

The same order of modules (presentness, directness, openness, and mutuality) was provided for each participant to ensure treatment fidelity. Further, participants were instructed in the same manner to ensure no additional contributing factor (e.g., spending extended time with the researcher) would influence the findings. Following institutional review board approval, the researcher reached out to local agencies in the community, therapist groups on Facebook, and used the online platform of Facebook to recruit for and promote the study. Of the five participants who completed this study, one came from a county run women's resource center, three from personal referrals on Facebook, and one from a therapist group on Facebook. Before beginning the study, each participant was read the consent form, consented, and provided a copy of the consent form. In addition, participants completed a screening questionnaire with the researcher on the phone. Participants were enrolled in the study based on their availability, and the overall data collection process for all participants occurred over a four-week time period.

Participants were enrolled in the study on an on-going basis, with the first participant being enrolled on February 24th, 2020 and the last participants being enrolled on March 4th, 2020. Data collection for three participants occurred within a window of ten consecutive days, with two participants (Participant 1 and Participant 3) who

experienced technology difficulties for one of their respective days of data collection completing data collection in an 11-day window. Despite the issue, each participant continued communicating with the researcher until resolved. Due to the difficulty with Canvas, the study returned to email format, and participants reported no problems thereafter. This data collection continued through the baseline, intervention, and postintervention phases of the study, with the researcher checking the data daily. Checking the data consistently and regularly aided in ensuring participant responses aligned with their respective day of the study (i.e., that participants responded "yes" when they had watched the video for the four modules and "no" when they had not yet watched the video for the four modules). The researcher used a three-point baseline before beginning the study as it is considered sufficient to establish level, stability, and trend (Kennedy, 2005; Ray, 2014; Lenz & Callender, 2018). Effect size was calculated with a comparison nonoverlapping method, for this study percentage of data exceeding the median (PEM) was utilized. PEM is recommended by the literature as most effective for SCRDs (e.g. A-B-A) with less than 10 data points (Lenz, Speciale, & Aguilar, 2012). In this current study PEM is used adjunctively, as suggested by the literature (Lenz, 2013), to support visual trend analysis on the value and usefulness of the dialogical relationship e-learning modules.

Research Question One

The first research question, "What is the course of response of individuals of low SES self-reported presentness, directness, openness and mutuality, with participation in

four e-learning dialogical modules?", was analyzed by the individual construct based on the participants' responses compared by phases – baseline compared to treatment phase and postintervention phase. Additionally, participants combined total score were analyzed to determine the overall effectiveness of the dialogical relationship e-learning modules (DREM). Mainly, the differences between participant responses were analyzed surrounding their confidence in the four dialogical skills when contrasted to their responses after receiving each DREM. Participants were asked to consider the definition provided and to respond regarding their ability to practice that specific dialogical skill. Responses were determined on a Likert Scale of "Strongly Disagree" to "Strongly Agree", with "Neither Agree nor Disagree" as a neutral point. For example, they were asked to agree with the statement, "I know how to be fully present," with the definition of presentness being "the ability through practice to cultivate our full attention in the present moment. It is to be completely and fully embodied (i.e., aware of all of our present moment experiences). It is to bring our attention and intention to the present moment."

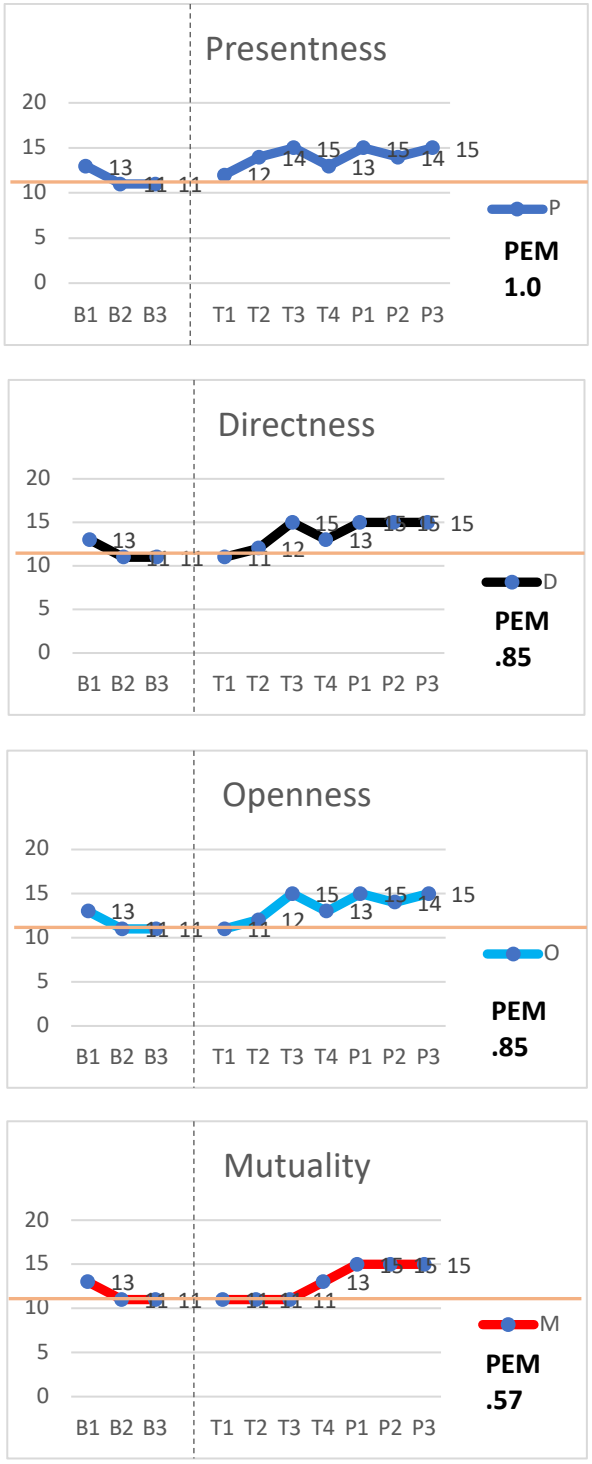


Figure 1. Effectiveness of DREM – Participant 1's Responses to Four Modules

Figure 1 presents the four modules for Participant 1 on their self-reported confidence in using the skill of presentness. Evaluation of the PEM statistics (1.0) for presentness indicated that all four scores of the treatment and the three scores during the postintervention phase were above the baseline median (11), suggesting a very effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the presentness skill suggested some variability between scores. The trend analysis suggested that the furthest data point increase from the baseline median was by four points. All data points exceed the PEM line and demonstrate that the DREM was effective at teaching the dialogical relationship skill of presentness for Participant 1, based on their self-reported confidence at using the skill of presentness.

Evaluation of the PEM statistics (.85) for directness indicated that three of the four scores during the treatment and all three scores during the postintervention phase were above the baseline median (11), suggesting a moderately effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the directness skill suggested initially no change on the first day of treatment and suggested an increase of score on day two, corresponding to the module on directness. A decrease in score occurred during the fourth day of treatment and returned to the highest previously reported score (15) on the first day of the postintervention phase. The trend analysis suggested that the furthest data point increase from the baseline median was by four points. All data points except one (T1) exceed the PEM line and suggest that the DREM was effective at teaching the dialogical relationship skill of directness for Participant 1, based on self-reported confidence at using the skill of directness.

Evaluation of the PEM statistics (.85) for openness indicated that three of the four scores of the treatment and all three during the postintervention phase were above the baseline median (11), demonstrating a moderately effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the openness skill during the intervention phase suggested the highest score directly after learning the module on day three of treatment. The trend analysis suggested that the furthest data point increase from the baseline median was by four points. All data points except one (T1) exceed the PEM line and demonstrate that the DREM was effective at teaching the dialogical relationship skill of openness for Participant 1, based on self-reported confidence at using the skill of openness.

Evaluation of the PEM statistics (.57) for mutuality indicated that one of the four scores of the treatment and three during the postintervention phase were above the baseline median (11), suggesting arguably an effective treatment (Scruggs & Mastropieri, 1998). It is important to note that mutuality was taught on day four of the treatment phase. The scores reflected, as expected, the highest scores on mutuality following module four - on day four of the treatment and thereafter. Overall, the mutuality skill seemed to increase and stabilized during the postintervention with a maximum score of fifteen. The trend analysis suggested that the furthest data point increase from the baseline median was by four points. Four data points exceed the PEM line (T4, P1, P2, P3) and support that the DREM was effective at teaching the dialogical relationship skill of mutuality for Participant 1, based on self-reported confidence in using the skill of mutuality.

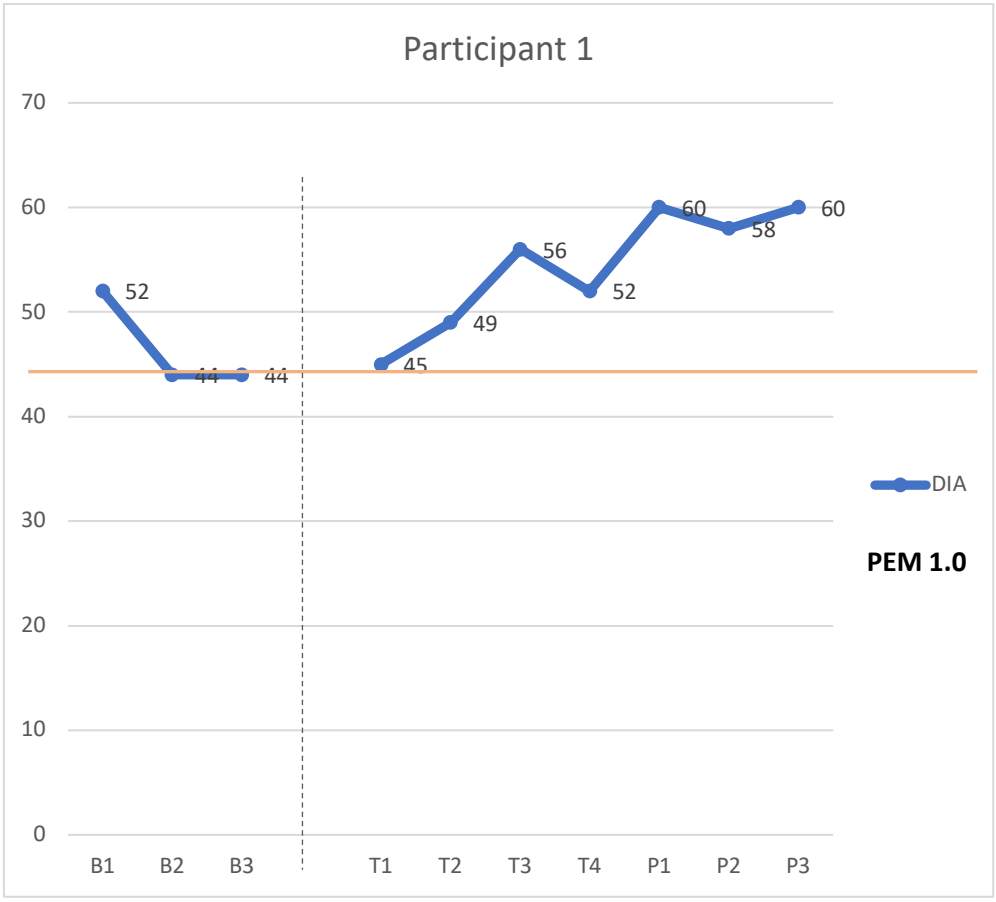
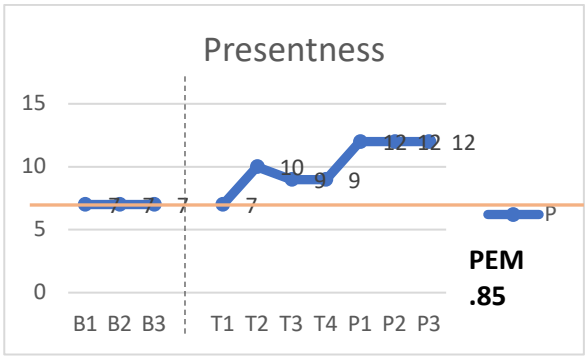
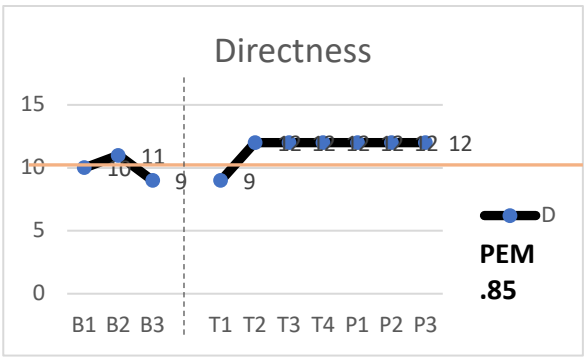


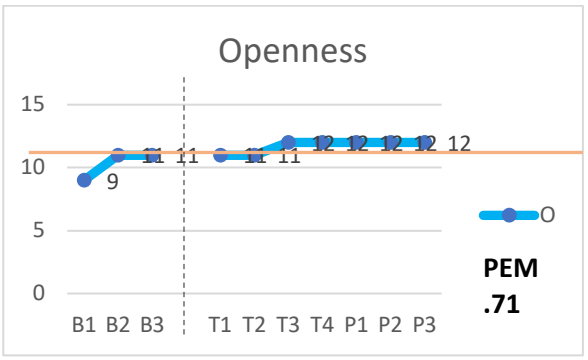
Figure 2. Overall Effectiveness of DREM – Participant 1's Total Scores

Figure 2 presents the ratings for Participant 1 on the overall effectiveness of the dialogical relationship e-learning modules (DREM), calculated by combining the four subscale scores. Evaluation of the PEM statistic (1.0) for DREM indicated that all four scores during the treatment phase and all three during the postintervention phase were above the baseline median (44), suggesting effective to very effective treatment effects (Scruggs & Mastropieri, 1998). A trend analysis of the dialogical relationship skills indicated an upward trend occurred after stabilizing following the baseline median. Two drops in the trend developed, with the first drop on the last treatment day (T4) and again

during the postintervention (P2). The trend analysis suggested that the furthest data point increase from the baseline median was by sixteen points. All data points exceed the PEM line and support that the DREM was effective in teaching the dialogical relationship skills for Participant 1, based on self-reported confidence in using the four dialogical relationship skills.







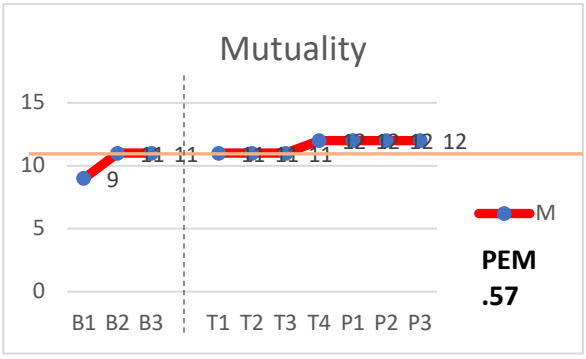


Figure 3. Effectiveness of DREM – Participant 2's Responses to Four Modules

Figure 3 presents the four modules for Participant 2 on the effectiveness of the DREM at teaching presentness. Evaluation of the PEM statistics (.85) for presentness indicated that three out of four scores of the treatment phase and the three scores during the postintervention phase were above the baseline median (7), suggesting a moderately effective treatment effect (Scruggs & Mastropieri, 1998). A trend analysis of the presentness skill suggested some variability between scores with two big increases in the reported scores occurring on day two of treatment and on postintervention day 1. The trend analysis suggested that the furthest data point increase from the baseline median was by five points. All data points except one (T1) exceed the PEM line and support that the DREM was effective at teaching the dialogical relationship skill of presentness for Participant 2, based on self-reported confidence in using the skill of presentness.

Evaluation of the PEM statistics (.85) for directness indicated that three of the four scores during the treatment and three scores during the postintervention phase were above the baseline median (10), suggesting a moderately effective treatment effect (Scruggs & Mastropieri, 1998). A trend analysis of the directness skill suggested initially

a decrease on the first day of treatment before increasing on day two after the completion of the module on directness. The trend analysis suggested that the furthest data point increase from the baseline median was by two points. All data points except one (T1) exceed the PEM line and support that the DREM was effective at teaching the dialogical relationship skill of directness for Participant 2, based on self-reported confidence at using the skill of directness.

Evaluation of the PEM statistics (.71) for openness indicated that two of the four scores of the treatment and three of the scores during the postintervention phase were above the baseline median (11), suggesting an effective treatment effect (Scruggs & Mastropieri, 1998). A trend analysis of the openness skill during the intervention phase suggested the highest score directly after learning the module on day three of the treatment phase. The trend analysis suggested that the furthest data point increase from the baseline median was by one point. All data points except two (T1, T2) exceed the PEM line and support that the DREM was effective at teaching the dialogical relationship skill of openness for Participant 2, based on self-reported confidence in using the skill of openness.

Evaluation of the PEM statistics (.57) for mutuality indicated that one of the four scores of the treatment and three of the scores during the postintervention phase were above the baseline median (11), suggesting arguably an effective treatment effect (Scruggs & Mastropieri, 1998). Important to note that mutuality was taught on day four of the treatment phase. Consistent with other participants, the highest mutuality score followed the corresponding module – on day four of the treatment and thereafter. Overall,

the mutuality skill seemed to increase and stabilized during the postintervention with a score of 12. The trend analysis suggested that the furthest data point increase from the baseline median was by one point. Four data points exceed the PEM line (T4, P1, P2, P3) and support that the DREM was arguably effective at teaching the dialogical relationship skill of mutuality for Participant 2, based on self-reported confidence at using these skills.

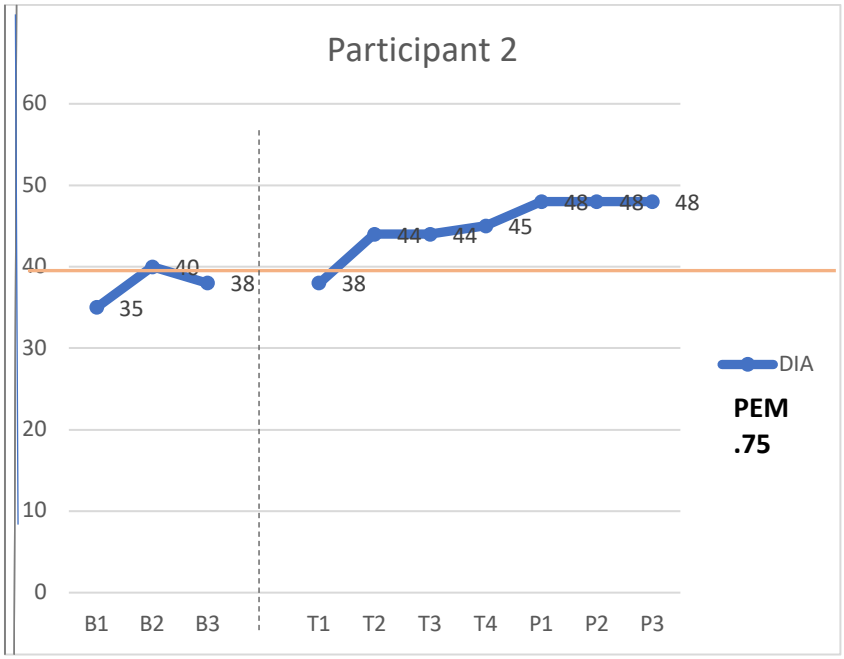
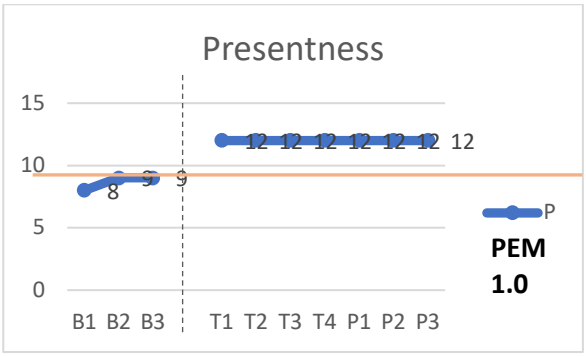
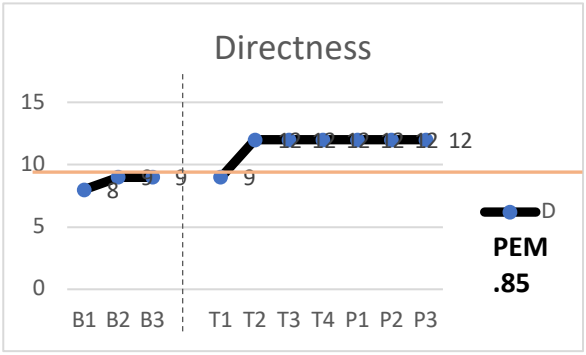


Figure 4. Overall Effectiveness of DREM – Participant 2's Total Scores

Figure 4 presents the ratings for Participant 2 on the overall effectiveness of the dialogical relationship e-learning modules (DREM), calculated by combining the four subscale scores. Evaluation of the PEM statistic (.85) for DREM indicated that three out of four scores during the treatment phase and all three during the postintervention phase were above the baseline median (38), suggesting moderately effective treatment effect (Scruggs & Mastropieri, 1998). A trend analysis of the dialogical relationship skills

indicated a fairly upward trend developed following the baseline median. The scores stabilized (48) and sustained during the postintervention phase. One datum point revealed no change (T1) from the baseline median (38). An upward trend developed starting on treatment day 2 (T2) and remained the same on treatment day 3 (T3) while increasing again on the last treatment day (T4). The trend analysis suggested that the furthest data point increase from the baseline median was by ten points. All data points except one (T1) exceed the PEM line and support that the DREM was quite effective in teaching the dialogical relationship skills for Participant 2, based on self-reported confidence in using these four skills.





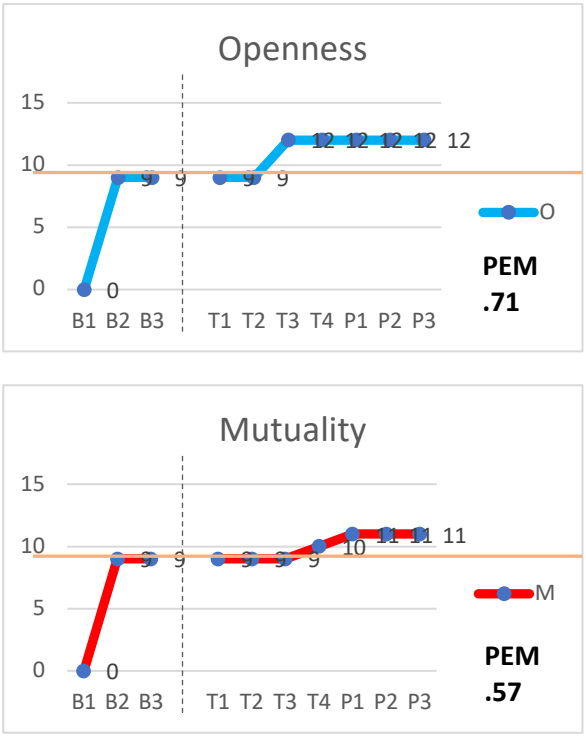


Figure 5. Effectiveness of DREM – Participant 3's Responses to Four Modules

Figure 5 presents the four modules for Participant 3 on the effectiveness of the DREM at teaching presentness. Evaluation of the PEM statistics (1.0) for presentness indicated that all four scores during the treatment phase and three scores during the postintervention phase were above the baseline median (9), suggesting an effective treatment effect (Scruggs & Mastropieri, 1998). A trend analysis of the presentness skill suggested no variability between scores during the treatment and postintervention phases. The trend analysis suggested that the furthest data point increase from the baseline median was by three points. All data points exceed the PEM line and support that the DREM was effective at teaching the dialogical relationship skill of presentness for Participant 3, based on self-reported confidence at using the skill of presentness.

Evaluation of the PEM statistics (.85) for directness indicated that three of the four scores during the treatment phase and the three scores during the postintervention phase were above the baseline median (9), suggesting a moderately effective treatment effect (Scruggs & Mastropieri, 1998). A trend analysis of the directness skill suggested no change on the first day of treatment and suggested an increase of score on day two after completing the module on directness. The trend analysis suggested that the furthest data point increase from the baseline median was by three points. All data points except one (T1) exceed the PEM line and support that the DREM was effective at teaching the dialogical relationship skill of directness for Participant 3, based on self-reported confidence at using the skill of directness.

Evaluation of the PEM statistics (.71) for openness indicated that two of the four scores of during the treatment phase and three scores during the postintervention phase were above the baseline median (9), suggesting an effective treatment effect (Scruggs & Mastropieri, 1998). A trend analysis of the openness skill during the intervention phase suggested the highest score directly after learning the module on day three of treatment. The trend analysis suggested that the furthest data point increase from the baseline median was by three points. All data points except two (T1, T2) exceeded the PEM line and support that the DREM was effective at teaching the dialogical relationship skill of openness for Participant 3, based on self-reported confidence at using the skill of openness.

Evaluation of the PEM statistics (.57) for mutuality indicated that one of the four scores during the treatment phase and three scores during the postintervention phase were

above the baseline median (9), suggesting arguably an effective treatment effect (Scruggs & Mastropieri, 1998). It is important to note that mutuality was taught on day four of treatment. Consistent with other participants, the highest scores on mutuality followed the corresponding module - on day four of the treatment and thereafter. Overall, the mutuality skill seemed to increase and stabilized during the postintervention with a score of eleven. The trend analysis suggested that the furthest data point increase from the baseline median was by two points. Four data points exceed the PEM line (T4, P1, P2, P3) and support that the DREM was arguably effective at teaching the dialogical relationship skill of mutuality for Participant 3, based on self-report of confidence at using the skill of mutuality.

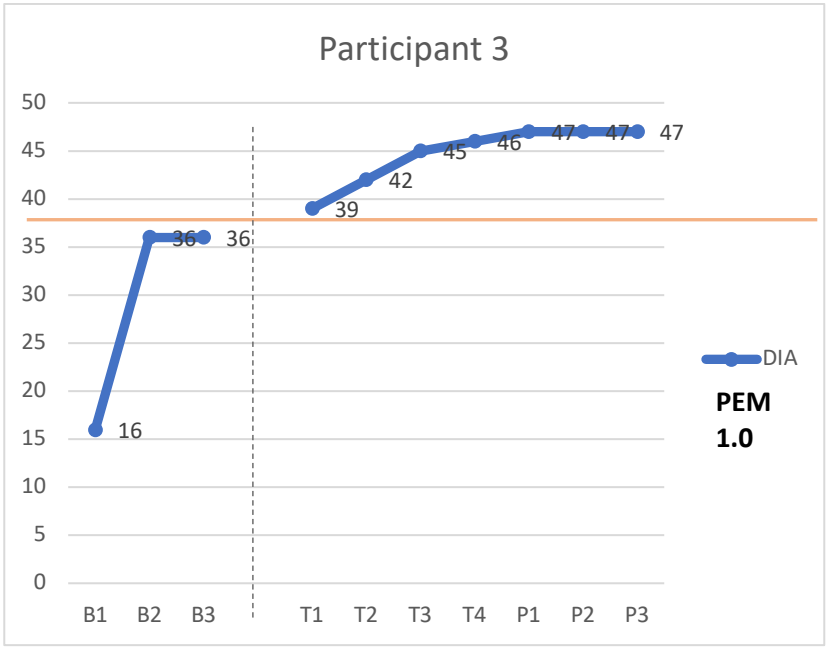
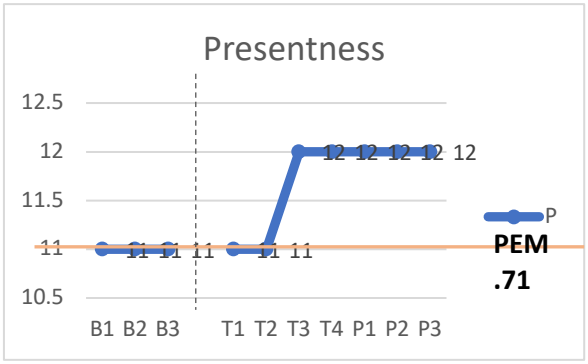
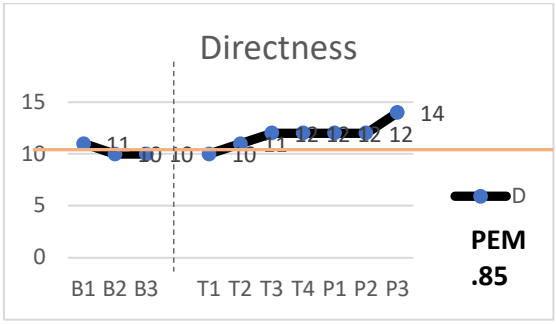


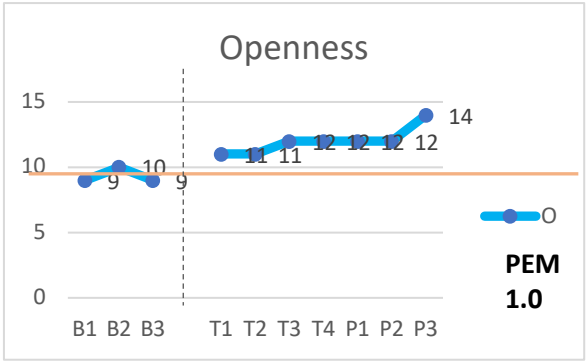
Figure 6. Overall Effectiveness of DREM – Participant 3's Total Scores

Figure 6 presents the ratings for Participant 3 on the overall effectiveness of the dialogical relationship e-learning modules (DREM), calculated by summing the subscale scores. Evaluation of the PEM statistic (1.0) for DREM indicated that all four scores during the treatment phase and all three during the postintervention phase were above the baseline median (36), suggesting effective to very effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the dialogical relationship skills indicated a steady upward trend following the baseline median. The scores stabilized (47) and sustained during the postintervention phase. Two data points suggested an increase between points by three points (T1,T2) and an increase between two data points of one point (T3,T4).The trend analysis suggested that the furthest data point increase from the baseline median was by eleven points. All data points exceed the PEM line and support that the DREM

was quite effective in teaching the dialogical relationship skills for Participant 3 based on self-report of confidence for using these four skills.







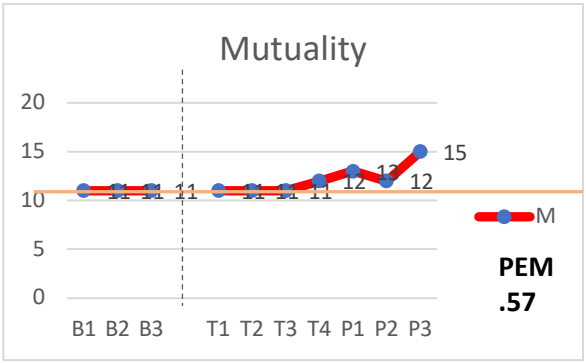


Figure 7. Effectiveness of DREM – Participant 4's Responses to Four Modules

Figure 7 presents the four modules for Participant 4 on the effectiveness of the DREM at teaching presentness. Evaluation of the PEM statistics (.71) for presentness indicated that three of the four scores during the treatment phase and the three scores during the postintervention phase were above the baseline median (11), suggesting an effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the presentness skill suggested no change on day one of treatment with an increase on day two. The trend analysis suggested that the furthest data point increase from the baseline median was by one point. All data points except one (T1) exceed the PEM line and support that the DREM was effective at teaching the dialogical relationship skill of presentness for Participant 4, based on self-reported confidence at using the skill of presentness.

Evaluation of the PEM statistics (.85) for directness indicated that three of the four scores during the treatment phase and three scores during the postintervention phase were above the baseline median (10), suggesting a moderately effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the directness skill suggested no change on the first day of treatment and suggested an increase of score on day two after

completing the module on directness. The trend analysis suggested that the furthest data point increase from the baseline median was by four points. All data points except one (T1) exceed the PEM line and support that the DREM was effective at teaching the dialogical relationship skill of directness for Participant 4, based on self-reported confidence at using the skill of directness.

Evaluation of the PEM statistics (1.0) for openness indicated that all four scores during the treatment phase and the three scores during the postintervention phase were above the baseline median (9), suggesting a very effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the openness skill during the intervention phase suggested the highest score directly after learning the module on day three of treatment (12) and remained consistent until a second increase on day three of the postintervention phase (14). The trend analysis suggested that the furthest data point increase from the baseline median was by five points. All data points exceed the PEM line and support that the DREM was very effective at teaching the dialogical relationship skill of openness for Participant 4 based on self-reported confidence at using the skill of openness.

Evaluation of the PEM statistics (.57) for mutuality indicated that one of the four scores during the treatment phase and the three scores during the postintervention phase were above the baseline median (11), suggesting arguably an effective treatment (Scruggs & Mastropieri, 1998). Important to note that mutuality was taught on day four of the treatment phase. Consistent with other participants, the highest scores on mutuality followed the corresponding module – on day four of the treatment and thereafter. The trend analysis suggested that the furthest data point increase from the baseline median

was by four points. Four data points exceed the PEM line (T4, P1, P2, P3) and support that the DREM was arguably effective at teaching the dialogical relationship skill of mutuality for Participant 4, based on self-reported confidence at using the skill of mutuality.

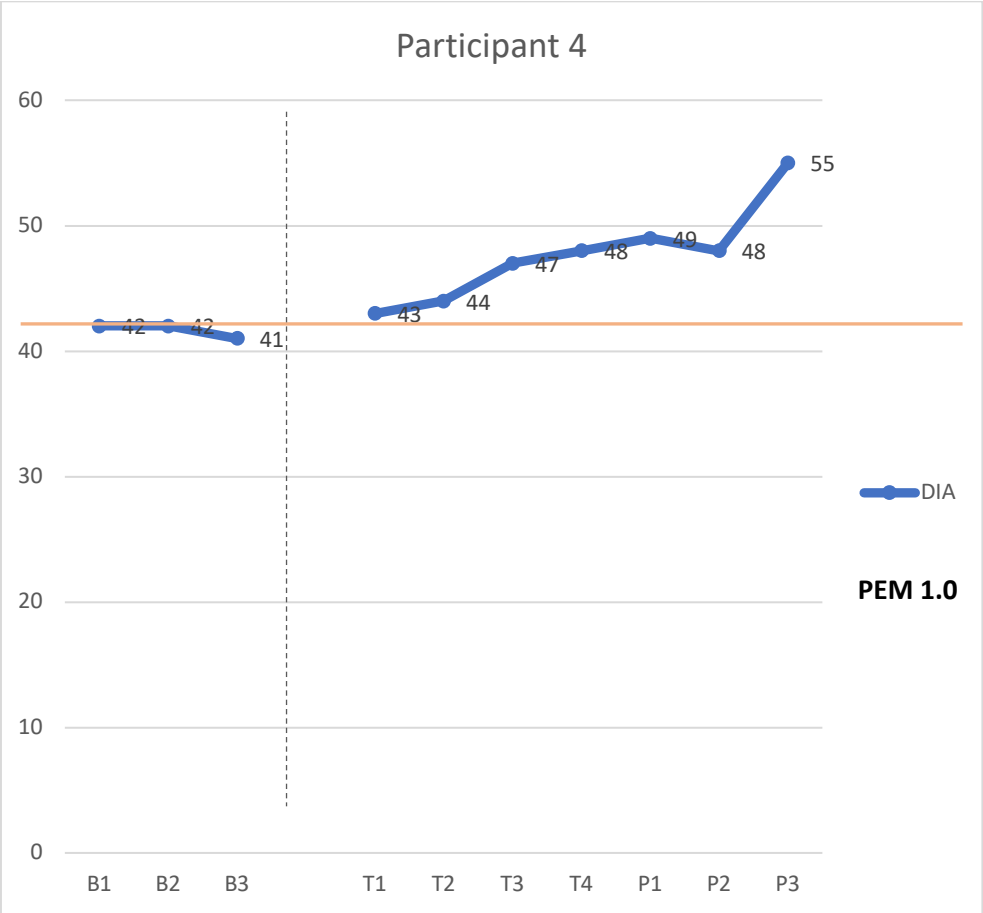
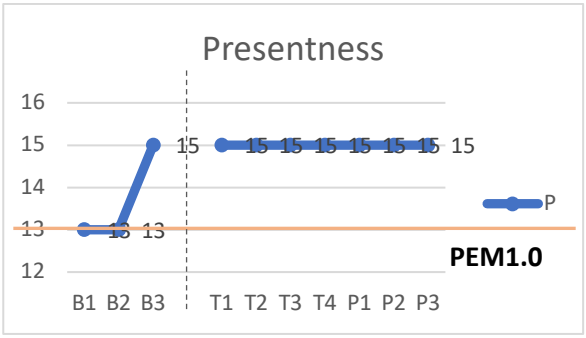
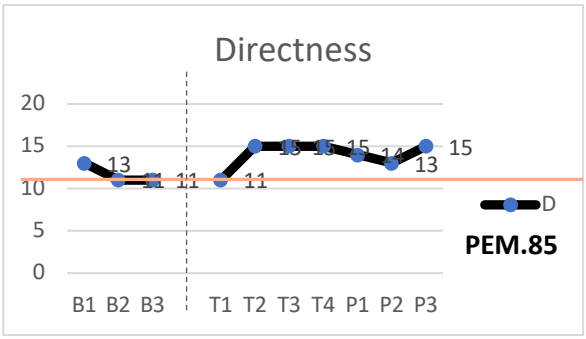


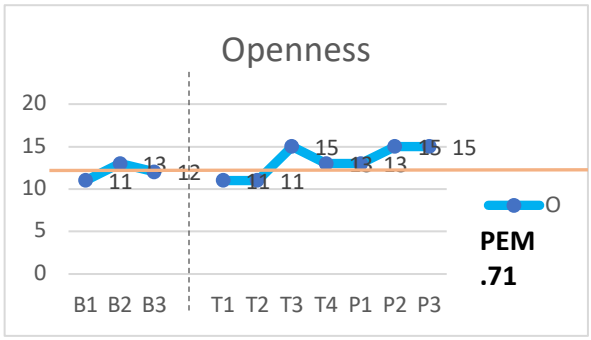
Figure 8. Overall Effectiveness of DREM – Participant 4's Total Scores

Figure 8 presents the ratings for Participant 4 on the effectiveness of the dialogical relationship e-learning modules (DREM), calculated by summing the four subscale scores. Evaluation of the PEM statistic (1.0) for DREM indicated that all four

scores during the treatment phase and all three during the postintervention phase were above the baseline median (42), suggesting effective to very effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the dialogical relationship skills indicated a consistent upward trend developed following the baseline. The trend analysis suggested that the furthest data point increase from the baseline median was by thirteen points. All data points exceed the PEM line and support that the DREM was quite effective in teaching the dialogical relationship skills for Participant 4, based on self-reported confidence in using the four dialogical relationship skills.


Presentness
16
15
14
13
12
15
13
P
PEM1.0
B1 B2 B3 T1 T2 T3 T4 P1 P2 P3


Directness
20
15
10
5
0
13
11
15
13
15
D
PEM.85
B1 B2 B3 T1 T2 T3 T4 P1 P2 P3


Openness
20
15
10
5
0
11
13
12
15
13
15
O
PEM
.71
B1 B2 B3 T1 T2 T3 T4 P1 P2 P3

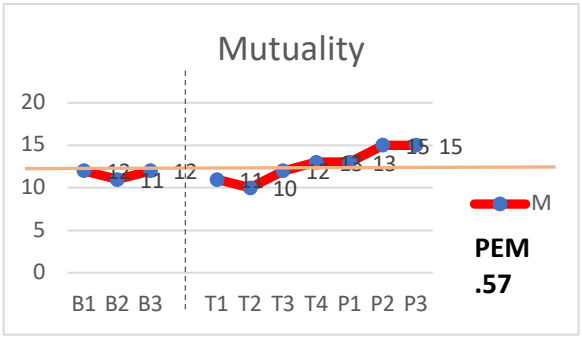


Figure 9. Effectiveness of DREM – Participant 5's Responses to Four Modules

Figure 9 presents the four modules for Participant 5 on the effectiveness of the DREM at teaching presentness. Evaluation of the PEM statistics (1.0) for presentness indicated that all four scores during the treatment phase and the three scores during the postintervention phase were above the baseline median (13), suggesting a moderately effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the presentness skill suggested no variability between scores in the treatment and postintervention phases. The trend analysis suggested that the furthest data point increase from the baseline median was by two points. All data points exceed the PEM line and support that the DREM was effective at teaching the dialogical relationship skill of presentness for Participant 5, based on self-reported confidence at using the skill of presentness.

Evaluation of the PEM statistics (.85) for directness indicated that three of the four scores during the treatment phase and the three scores during the postintervention phase were above the baseline median (11), suggesting a moderately effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the directness skill suggested initially no change on the first day of treatment and suggested an increase of score on day two

after the module on directness. A decrease in score occurred during two of the postintervention days before returning to the highest previous score (15) on the third day of postintervention. On postintervention day one and two of treatment with an increase on day three and a decrease on day four. The trend analysis suggested that the furthest data point increase from the baseline median was by four points. All data points except one (T1) exceed the PEM line and support that the DREM was moderately effective at teaching the dialogical relationship skill of directness for Participant 5, based on self-reported confidence in using the skill of directness.

Evaluation of the PEM statistics (.71) for openness indicated that two of the four scores during the treatment phase and the three scores during the postintervention phase were above the baseline median (12), suggesting an effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the openness skill suggested an initial decrease on day one and two of treatment with an increase on day three and a decrease on day four. Overall, the openness skill seemed to increase and seemed to stabilize during the postintervention with a maximum score of 15. The trend analysis suggested that the furthest data point increase from the baseline median was by three points. All data points except two (T1, T2) exceed the PEM line and support that the DREM was effective at teaching the dialogical relationship skill of openness for Participant 5, based on self-reported confidence in using the skill of openness.

Evaluation of the PEM statistics (.57) for mutuality indicated that one of the four scores during the treatment phase and the three scores during the postintervention phase were above the baseline median (12), suggesting arguably an effective treatment (Scruggs

& Mastropieri, 1998). Important to note that mutuality was taught on day four of treatment, and lower scores on the skill were expected on days previous to the introduction of skill. Consistent with this expectation is the raised scores on mutuality during day four and postintervention days one, two, and three. A trend analysis of the mutuality skill suggested an initial decrease on day one and two of treatment with a return to the baseline median on day three before surpassing the PEM line on day four and during postintervention day one through three. Overall, the mutuality skill seemed to increase and stabilized during the postintervention with a maximum score of 15. The trend analysis suggested that the furthest data point increase from the baseline median was by three points. Four data points exceed the PEM line (T4, P1, P2, P3) and support that the DREM was arguably effective at teaching the dialogical relationship skill of mutuality for Participant 5, based on self-reported confidence in using the skill of mutuality.

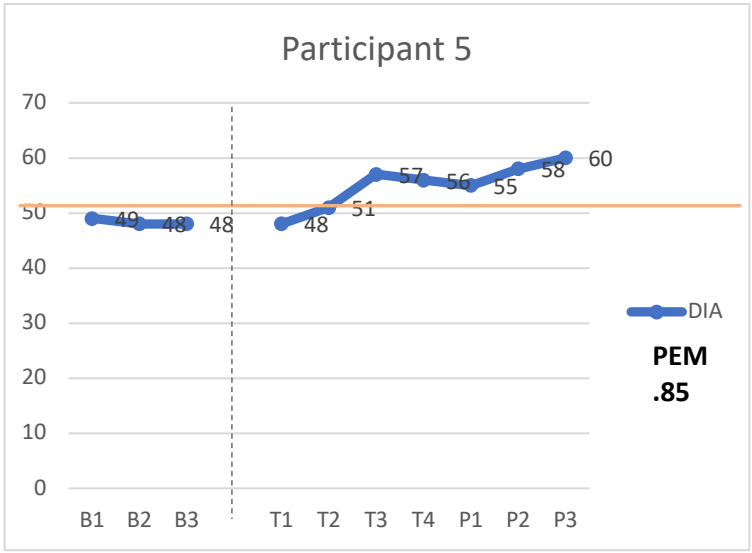


Figure 10. Overall Effectiveness of DREM – Participant 5's Total Scores

Figure 10 presents the ratings for Participant 5 on the overall effectiveness of the dialogical relationship e-learning modules (DREM), calculated as the sum of the four subscales. Evaluation of the PEM statistic (.85) for DREM indicated that three out of four scores during the treatment phase and all three during the postintervention phase were above the baseline median (48), suggesting moderately effective treatment (Scruggs & Mastropieri, 1998). A trend analysis of the dialogical relationship skills indicated a moderate upward trend developed following the baseline. Treatment day 1 (T1), revealed no change (48) from the baseline and increased on T2 and T3. The trend analysis shows a downward trend on T4 and P1 (56,55) and an upward trend on P2 and P3 (58,60). The furthest data point increase from the baseline median was by eleven points. All data points except one (T1) exceed the PEM line and support that the DREM was moderately

effective in teaching the dialogical relationship skills for Participant 5, based on self-reported confidence in using the four dialogical relationship skills.

Research Question Two

The second research question was, "To what degree are the four e-learning dialogical modules efficacious for increasing relationship quality over time?" The five participants completed the 7-item Relationship Assessment Scale (RAS) before receiving the intervention in a three-time measure baseline. While a more extended baseline is encouraged (Lenz & Callender, 2018), due to the time constraints the 3-data point minimum was utilized for the present exploratory study. SCRDs are reported visually and are done so below. Additionally, as suggested by Holtz et al. (2015), an effect was calculated.

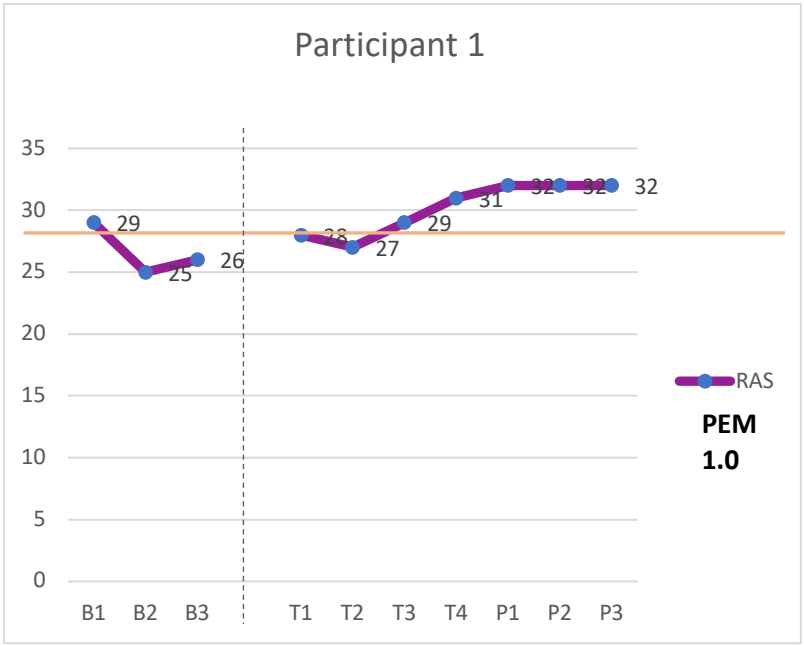


Figure 11. Relationship Satisfaction – Participant 1's Responses

Figure 11 presents the ratings for Participant 1 on the efficaciousness of the dialogical relationship e-learning modules (DREM), increasing relationship satisfaction as measured by the Relationship Assessment Scale (RAS). Evaluation of the PEM statistic for RAS (1.0) indicated that all four scores during the treatment phase and all three during the postintervention phase were above the baseline median (26), suggesting treatment effectiveness for this domain following the baseline. Treatment day 1 (T1) revealed an increase (28) from the baseline and decreased on T2 (27). The trend analysis shows an increase and steady upward trend from T3 to P1(29, 32) and stabilized during P2 and P3 (32,32). The furthest data point increase from the baseline median was by six points. All data points exceed the PEM line and support that the DREM was quite

effective in increasing relationship satisfaction for Participant 1 and that higher levels were maintained after the conclusion of the intervention.

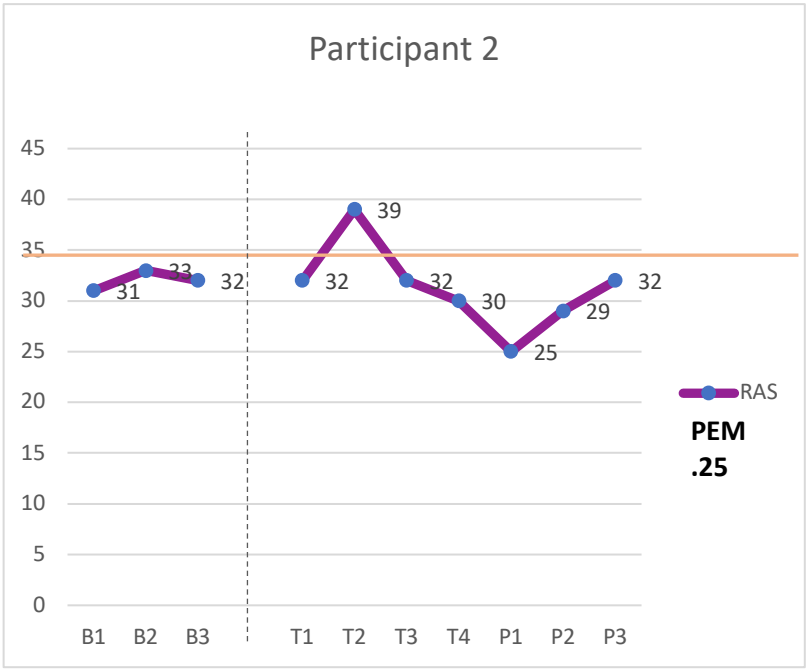


Figure 12. Relationship Satisfaction – Participant 2's Responses

Figure 12 presents the ratings for Participant 2 on the efficaciousness of the dialogical relationship e-learning modules (DREM), increasing relationship satisfaction as measured by the Relationship Assessment Scale (RAS). Evaluation of the PEM statistic for RAS (.25) indicated that only one score during the treatment phase was above the baseline median (32), suggesting treatment ineffectiveness. Trend analysis indicated that two of the four scores reported during the treatment phase remained at the baseline median (32). The trend analysis suggested that three scores (T3, P1, P2) were below the baseline median before returning to the baseline median on P3. The furthest data point

increase from the baseline median was by seven points. While one score during the treatment phase was above the PEM line, the three scores on the PEM line and the three scores below suggest that the DREM was ineffective in increasing relationship satisfaction for Participant 2.

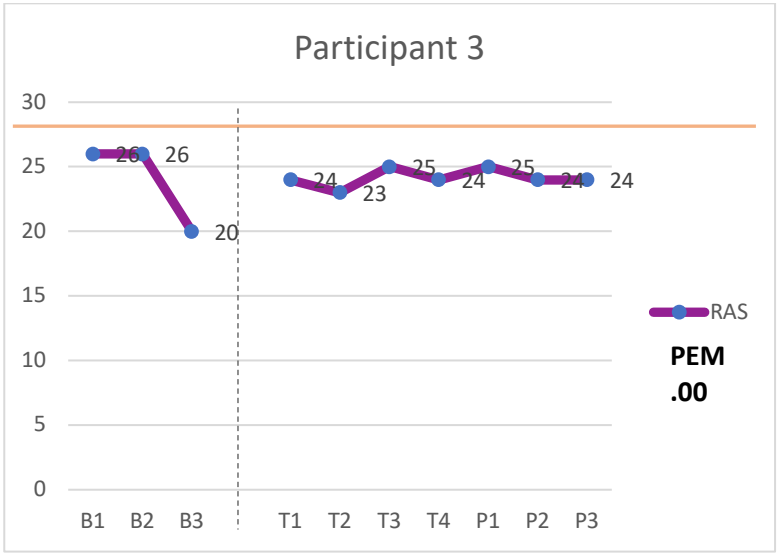


Figure 13. Relationship Satisfaction – Participant 3's Responses

Figure 13 presents the ratings for Participant 3 on the efficaciousness of the dialogical relationship e-learning modules (DREM), increasing relationship satisfaction as measured by the Relationship Assessment Scale (RAS). Evaluation of the PEM statistic for RAS (.00) indicated that all scores during the treatment phase were below the baseline median (26), suggesting treatment ineffectiveness for this domain for this participant. Trend analysis indicated that a one-point difference existed between four data points (T1, T2, and T3, T4, P1) with the two data points remaining the same (P2, P3). The furthest data point decrease from the baseline median was by three points. The total

of four scores during treatment and three during the postintervention were below the PEM line, suggesting that the DREM was ineffective in increasing relationship satisfaction for Participant 3.

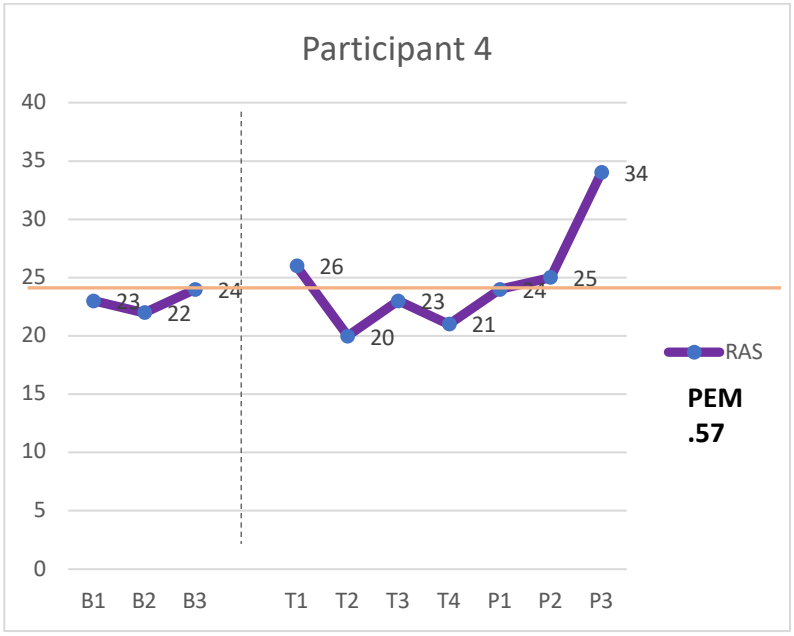


Figure 14. Relationship Satisfaction – Participant 4's Responses

Figure 14 presents the ratings for Participant 4 on the efficaciousness of the dialogical relationship e-learning modules (DREM), increasing relationship satisfaction as measured by the Relationship Assessment Scale (RAS). Evaluation of the PEM statistic for RAS (.57) indicated that all scores during the treatment phase were below the baseline median (23), suggesting treatment ineffectiveness for this domain for this participant. Trend analysis indicated one datum point in the intervention phase was above the baseline median (23) and a decreased below or at the PEM line for three data points (T2,T3,T4). Interestingly, however, despite the lack of evidence of treatment

effectiveness during the intervention phase, postintervention data indicate a strong trend upward in reported relationship quality. The furthest data point increase from the baseline median was by eleven points. While one score during the treatment phase was above the baseline median, three were at the PEM line or below. The trend analysis suggested an abrupt shift to the trend occurred with all three scores during the postintervention phase being above the PEM line. All scores except one during treatment (T1) were below the PEM line and the three scores for the postintervention phase was above the PEM line, suggesting that the DREM arguably was an effective treatment for participant 4 with some delay in increases in perceived relationship quality.

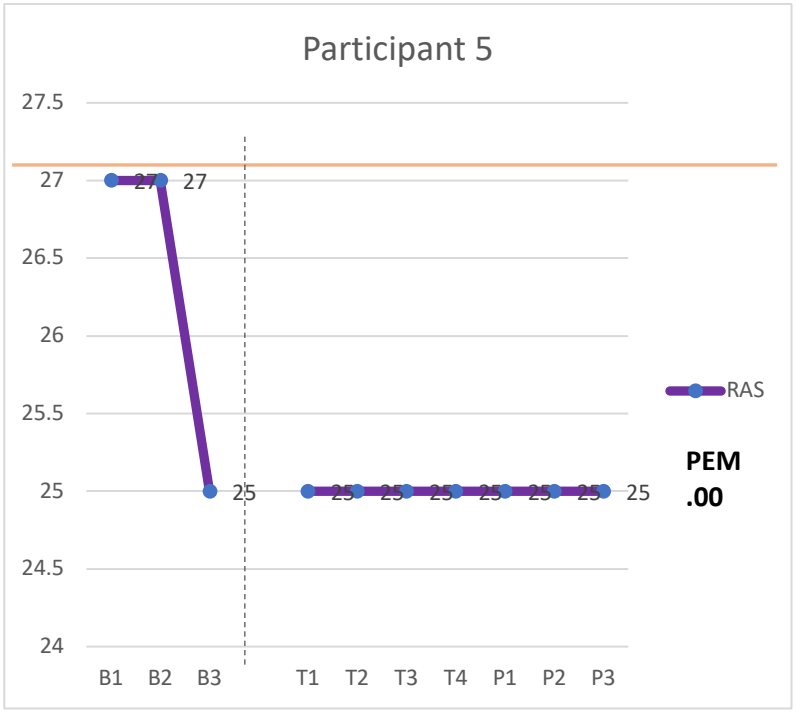


Figure 15. Relationship Satisfaction – Participant 5's Responses

Figure 15 presents the ratings for Participant 5 on the efficaciousness of the dialogical relationship e-learning modules (DREM), increasing relationship satisfaction as measured by the Relationship Assessment Scale (RAS). Evaluation of the PEM statistic for RAS (.00) indicated that all scores during the treatment phase were below the baseline median (27), suggesting treatment ineffectiveness for this domain for this participant. Trend analysis indicated no difference between treatment and postintervention scores (T1 through P3; 25). The furthest data point decrease from the baseline median was by two points. The four scores during treatment and the three scores during the postintervention phase were below the PEM line suggest that the DREM was ineffective in increasing relationship satisfaction for Participant 5.

Research Question Three

The third research question is, "To what degree are the dialogical e-learning modules efficacious in increasing QoL over the course of the intervention?" Due to the brief nature of the intervention, it was theorized that some change might appear in the data collection, but that substantive change was unlikely in a short-term intervention. The BBQ scores of each participant are reported and will be discussed for each participant.

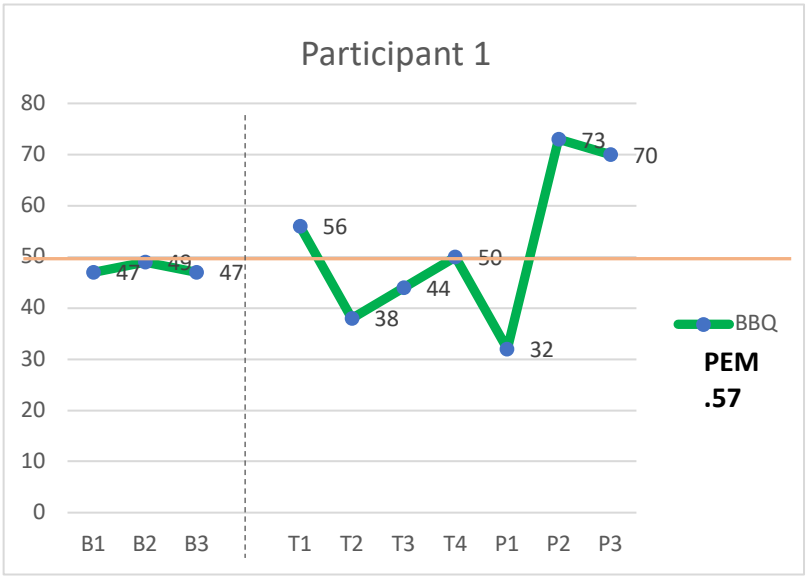


Figure 16. Quality of Life – Participant 1's Responses

Figure 16 presents the ratings for Participant 1 on the efficaciousness of the dialogical relationship e-learning modules (DREM) in increasing QoL. Evaluation of the PEM statistic for QoL (.57) indicated two scores during the treatment (T1, T4), and two scores during the postintervention (P2, P3) phase were above the baseline median (47), suggesting a debatable treatment effect for this domain. The trend analysis suggested that three scores (T2, T3, P1) were below the baseline median before developing an upward

trend exceeding PEM line. The trend analysis indicates that the furthest data point increase from the baseline median was by twenty-two points. Further there was substantial variability in scores with no clear trend in the data. Although two of the three scores in the follow-up data were above the median, the high degree of variability in the results throughout the treatment and follow-up phases raise questions as to whether the intervention systematically impacted QoL for Participant 1.

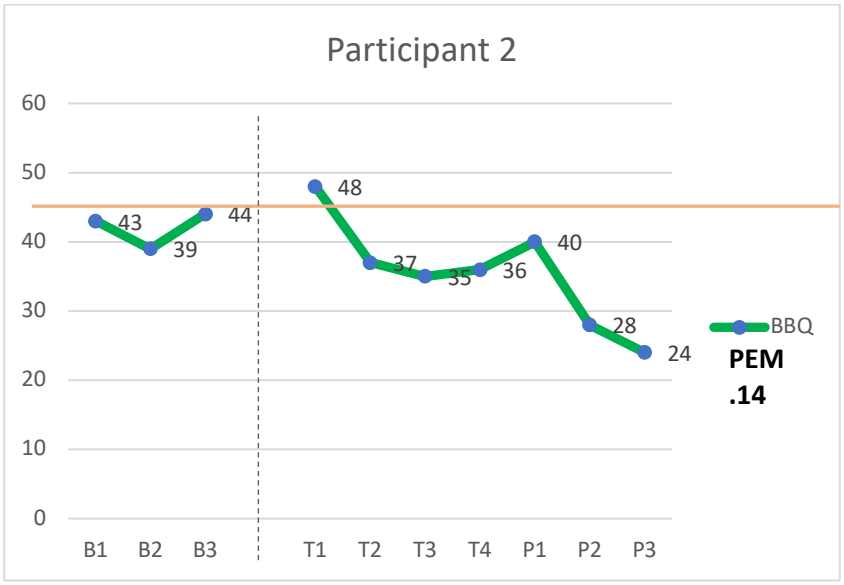


Figure 17. Quality of Life – Participant 2's Responses

Figure 17 presents the ratings for Participant 2 on the efficaciousness of the dialogical relationship e-learning modules (DREM) increasing quality of life (QoL) as measured by Brunnsviken Brief Quality of Life Scale (BBQ). Evaluation of the PEM statistic for QoL (.14) indicated only one score during the treatment (T1) was above the baseline median (43), suggesting that the treatment did not positively impact QoL for Participant 2. The trend analysis suggested that six scores (T2, T3, T4, P1, P2, P3) were

below the baseline median. The trend analysis suggested an initial score increase from the baseline median (T1) before developing a downward trend below the PEM line. The trend analysis indicates that the furthest data point decrease from the baseline median was by nine points. The one score above the PEM line and six scores below the baseline median suggest the DREM was ineffective in increasing QoL for Participant 2.

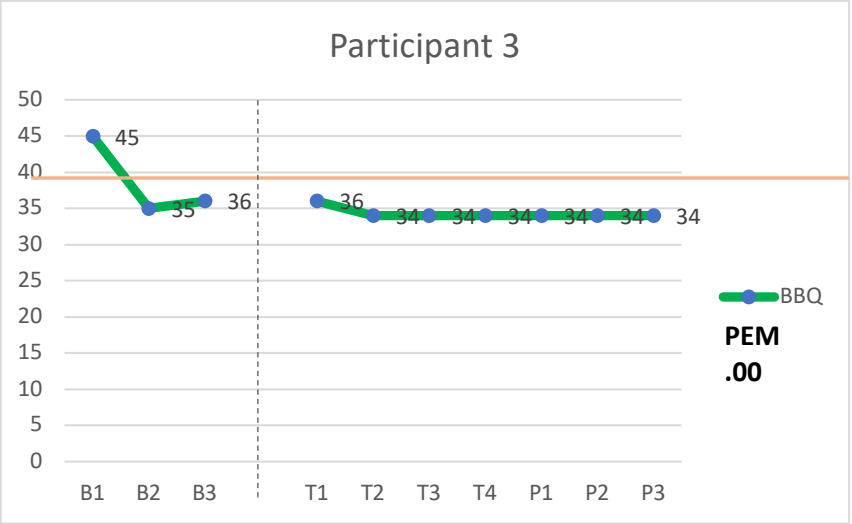


Figure 18. Quality of Life – Participant 3's Responses

Figure 18 presents the ratings for Participant 3 on the efficaciousness of the dialogical relationship e-learning modules (DREM) increasing quality of life (QoL) as measured by Brunnsviken Brief Quality of Life Scale (BBQ). Evaluation of the PEM statistic for QoL (.00) indicated that all scores during the treatment were below the baseline median (36), suggesting ineffective treatment effect for this domain. The trend analysis suggested that one score (T1) was equal to the baseline median scores, and all other scores (T2, T3, T4, P1, P2, P3) were below the baseline median. The trend analysis

suggested no change from the baseline median for one score (T1) before decreasing below the PEM line and demonstrating no variability for the remaining data points (T2, T3, T4, P1, P2, P3). The trend analysis indicates that the furthest data point decrease from the baseline median was only by two points. The seven scores at or below the PEM line suggests the DREM was ineffective in increasing QoL for Participant 3.

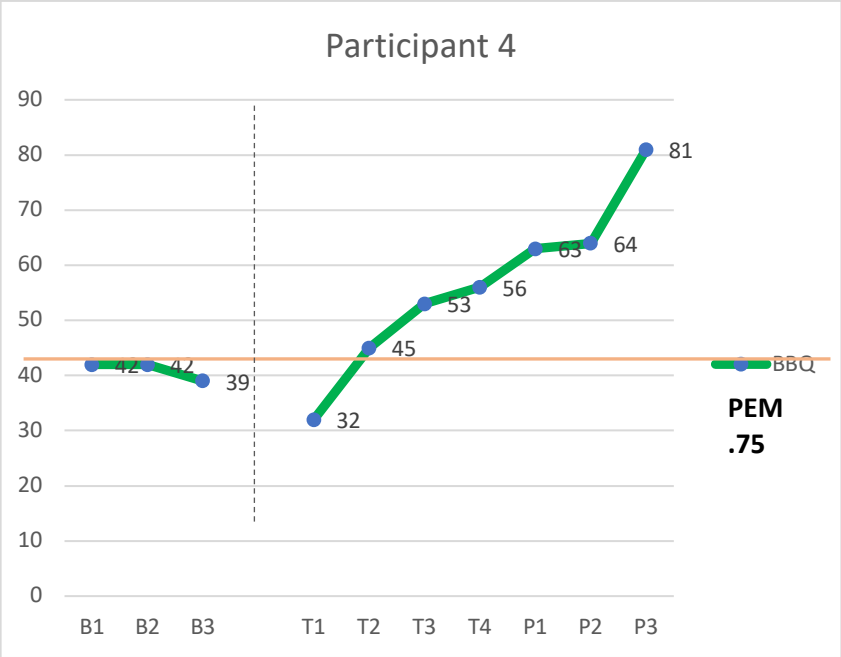


Figure 19. Quality of Life – Participant 4's Responses

Figure 19 presents the ratings for Participant 4 on the efficaciousness of the dialogical relationship e-learning modules (DREM) increasing quality of life (QoL) as measured by Brunnsviken Brief Quality of Life Scale (BBQ). Evaluation of the PEM statistic for QoL (.75) indicated all scores except one (T1) during the treatment were above the baseline median (42), suggesting a moderate treatment effect for this domain.

The trend analysis suggested one score (T1) abruptly dropped below the baseline median and an upward trend thereafter (T2, T3, T4, P1, P2, P3). The trend analysis suggested a steep decrease from the baseline median for one score (T1; 32) before increasing above the PEM line and demonstrating a steady upward trend (T2, T3, T4, P1, P2, P3). The trend analysis indicates that the furthest data point increase from the baseline median was by thirty-nine points. The six scores above the PEM line suggests that the DREM was quite effective in increasing QoL for Participant 4.

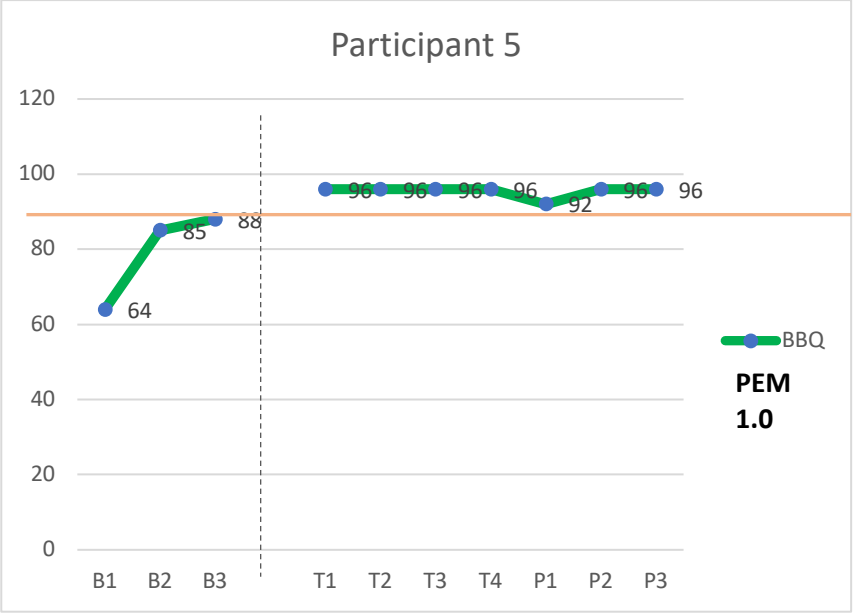


Figure 20. Quality of Life – Participant 5's Responses

Figure 20 presents the ratings for Participant 5 on the efficaciousness of the dialogical relationship e-learning modules (DREM) increasing quality of life (QoL) as measured by Brunnsviken Brief Quality of Life Scale (BBQ). Evaluation of the PEM statistic for QoL (1.0) indicated that all scores during the treatment were above the

baseline median (85), suggesting a strong treatment effect for this domain. The trend analysis suggested, however, little variability between data points. Only one datum point showed a variation (P1) from other data points (T1, T2, T3, T4, P2, P3). The trend analysis suggested a change from the baseline median of eight points before stabilizing around a score of 96. The trend analysis indicates that the furthest data point increase from the baseline median was by eleven points. The seven scores above the PEM line suggest that the DREM was effective in increasing QoL for Participant 5.

Summary

The purpose of Chapter 4 was to report the results of each single case study, including the analyses conducted to answer the three research questions outlined in Chapters 1 and 3. Overall, findings suggest that the dialogical relationship e-learning modules intervention had varying degrees of impact on the participants who completed the study, with participants showing significant treatment effects in some areas but not others. In Chapter 5, the results presented in this chapter will be discussed in greater length and discussed as they apply to existing research. Further, implications and recommendations for counselors, researchers, and counselor educators will be detailed as well as the limitations of the current study.

CHAPTER V

DISCUSSION

Positioned within the extensive literature of multiculturalism, low SES, and the lack of attention to counseling interventions oriented specifically to meet the needs of those in lower SES groups (Bernal, 2006; Clark et al., 2018; Cook et al., 2019; Cook & Lawson, 2016; Rodriguez et al., 2010), the present study focused on an initial evaluation of the dialogical relationship e-learning modules (DREM) in enhancing relationship quality through a culturally sensitive approach for individuals of low SES. Results suggested impact in some domains such as the effectiveness of DREM in teaching dialogical skills, based on self-reported confidence of participants to use these skills, yet seemed ineffective for some participants in increasing relationship satisfaction and quality of life.

Purported in this study was the development of an alternative to traditional counseling to meet the needs of individuals from low SES households (Liu et al., 2004). Because those in low SES households have limited access to culture-specific interventions and mental health services, the researcher posited that life stressors may inordinately impact the quality of life, including relationship satisfaction, among members of low-SES groups. Dakin and Wampler (2008) reported that individuals from low-SES populations who experience stressful life events and mental health problems increasingly report relationship dissatisfaction when contrasted with individuals from

wealthier populations. In consideration of these stressors and the lack of counseling interventions normed with low-SES groups, the dialogical relationship e-learning intervention was implemented with five participants who identified as low SES and met the criteria of the study.

Chapter 4 described the results for each participant. This chapter contextualizes the findings within the literature, first by highlighting over-arching findings and then by looking at the findings by research question. In addition, possible reasons grounded in the literature are presented for participants' negative trends within relationship satisfaction and QoL. Further, limitations of the study, implications for counselors, and recommendations for future research are recommended.

Results provided possible areas for further exploration as it pertains to the DREM as one way to enhance dialogical relationships among low-SES groups, further supporting a fullness of living (Friedman, 1988). Interestingly, albeit based on a short timeframe, the skills of the dialogical relationships were carried over into the postintervention phase. Additionally, confidence in skill increased after participants learned the DREM that corresponded to the skill.

Further research will provide vital information about the longer-term impact of the DREM training. One other over-arching finding of interest was a trend of relationship satisfaction decreasing as the study progressed. Although it is not possible to know for certain the cause of this, one possibility is that training in the dialogical relationship model highlights for people some of what may be lacking in their relationship. Somewhat surprisingly, for several of the participants for whom relationship satisfaction decreased

or did not improve, Quality of Life (QoL) demonstrated an upward trend. Future research is needed to further tease apart the nuances of within (intrapersonal) and between (interpersonal) aspects of the dialogical model. Attention is turned now to findings organized by participant.

Participant Results

Participant 1. The dialogical relationship e-learning modules appeared to be effective in increasing the confidence of implementing some of the dialogical relationship skills (presentness, directness, & openness) based on the participant's self-reports. All four dialogical skills remained above the PEM line, indicating effectiveness during the postintervention phase based on participant's self-reports. Initially, the participant showed a small change on the first day of treatment when they learned about presentness. An interesting finding was that the participant's scores regarding her confidence in implementing skills in presentness continued to increase and reach their highest reported score day three, perhaps suggesting that time may influence the integration of presentness skills. Additionally, directness, openness, and mutuality all increased after the completion of their corresponding module. However, an important note was the decrease of presentness, directness, and openness on day four (mutuality). Possibly, mutuality – a more complex construct – somehow influenced the decrease on day four for the other three constructs.

Relationship satisfaction increased on day 1 of treatment (presentness), decreased on day 2 (directness), increased on day 3 (openness), and increased on day 4 of treatment

(mutuality). It is unclear why these variations occurred, though it is possible that scores decreased and increased based on the level of personal difficulty this person had with these DREM constructs. Quality of life, as measured by Brunnsviken Brief Quality of Life Scale, increased on day 1 of treatment (presentness), decreased on day 2 (directness), increased on day 3 (openness), and increased past the PEM line on day 4 of treatment (mutuality). Finally, there was an initial decrease in P1 before significantly increasing on P2 and P3 (32,73,70). It is notable that QoL scores for Participant 1 fluctuated throughout the study and seemed most high during the postintervention. Although this could be due to testing effects, it also is possible that there is some lapse between increased confidence in the relationship skills and a noticeable improvement to quality of life.

Participant 2. The dialogical relationship e-learning modules appeared to be effective in increasing the confidence of implementing some of the dialogical relationship skills (presentness, directness, & openness) based on the participant's self-reports. Initially, the participant did not report any change in scores for presentness. The highest reported score occurred during the treatment phase for presentness on day two of the treatment phase – following the presentness module. Directness, openness, and mutuality all increased after the completion of their corresponding module. Relationship satisfaction stayed the same on day 1 of treatment (presentness), increased on day 2 (directness), decreased on day three (openness), and decreased on day 4 (mutuality). Although it is not possible to fully discern what occasioned these decreases, it may have been either exposure to more complex relationship constructs and/or the recognition based on the psychoeducation of deficiencies in their intimate relationship. On the first

day of the postintervention phase, the most significant decrease in reported relationship satisfaction before returning to the PEM line on days 2 and 3 (P2, P3). Quality of life (QoL) as measured by Brunnsviken Brief Quality of Life Scale increased on day 1 of treatment (presentness), decreased on day 2 of treatment (directness), decreased further on day 3 (openness), and increased on day 4 of treatment (mutuality). However, scores never returned above the PEM line and decreased again on P2 and further on P3. It is unknown whether the decrease in QoL scores was directly influenced by the training or, as is possible with more labile constructs, may have been an artifact of other life circumstances.

Participant 3. The dialogical relationship e-learning modules appeared to be effective in increasing the confidence of implementing some of the dialogical relationship skills (presentness, directness, & openness) based on the participant's self-reports. This participant reported an initial increase from the PEM line on day one of treatment but then remained consistent throughout the remaining of the study. Directness, openness, and mutuality were consistent with trends across participants increasing after the completion of the corresponding module. Relationship satisfaction increased on day 1 of treatment (presentness), showed a small decrease on day 2 (directness), increased on day 3 (openness), and decreased on day 4 (mutuality) while staying relatively the same during postintervention. Given the lack of a trend in the data, no conclusive results can be drawn. It is possible, however, that there was something unique about the constructs discussed in each module that may have either improved or decreased self-reported relationship satisfaction. Quality of life (QoL) as measured by Brunnsviken Brief Quality

of Life Scale, stayed the same on day 1 of treatment (presentness), decreased on day 2 (directness) and stayed consistent with no variation for the remaining days of treatment and during all three days in the postintervention phase. Accordingly, there were no clear trends to suggest that relationship satisfaction was explicitly connected to quality of life for this participant.

Participant 4. The dialogical relationship e-learning modules appeared to be effective in increasing the confidence of implementing some of the dialogical relationship skills (presentness, directness, & openness) based on the participant's self-reports for Participant 4 based on her self-report. All four constructs increased after the completion of the corresponding module. Relationship satisfaction increased on day 1 of treatment (presentness), decreased on day 2 (directness), increased back to the PEM line on day 3 (openness), and decreased on day 4 (mutuality). Scores returned above the PEM line during postintervention. Quality of life (QoL) as measured by Brunnsviken Brief Quality of Life Scale decreased on day 1 of treatment (presentness), increased past the PEM line on day 2 (directness), increased on day 3 (openness), and increased on day 4 of treatment (mutuality). Increases occurred each day of postintervention, with the highest score of the entire study occurring on the last day (P3). Although it is possible that the increased scores in the postintervention phase for both relationship satisfaction and quality of life is attributable to testing effects, it also may be that the information from the modules takes time to be fully integrated, resulting in some delay in improvements.

Participant 5. The dialogical relationship e-learning modules appeared to be effective in increasing the overall confidence of implementing some of the dialogical

relationship skills (presentness, directness, & openness) based on the participant's self-reports for Participant 5 based on her self-report. Participant 5 reported the maximum score for presentness, and the scores remained consistent with no change from the PEM line, possibly suggesting that the participant felt confident about this construct before beginning the treatment phase. Directness, openness, and mutuality increased after the corresponding module. On the other hand, however, no change occurred in the participant's reported relationship satisfaction through the entire intervention and postintervention phase. The lack of change in the report may potentially demonstrate the state of the intimate relationship (i.e., a longer committed relationship that may be less influenced by a brief intervention). Quality of life (QoL) as measured by Brunnsviken Brief Quality of Life Scale increased on treatment day 1 (presentness), while day 2, 3, and 4 of the treatment resulted in no variability of QoL scores. A decrease occurred in day 1 (P1) of the postintervention phase but returned to previously reported scores on days 2 and 3 (P2, P3). Accordingly, it is unknown whether the high scores and little variation of QoL were artifacts of other life circumstances or personal beliefs that circumvented any possible influences of the DREM intervention.

Dialogical Relationship E-learning Modules

As expected, with psychoeducation intervention, a carryover effect was present during the postintervention phase (Ray, 2014). The skills learned, thus, continued to impact the participants' scores. The results of this study found that three out of the five participants reported a noteworthy amount of change during the postintervention phase,

varying between day one of treatment and the last day of postintervention. Another study found, similarly, that couples and relationship education (CREs) are an effective method of strengthening relationship amongst individuals of low SES (Cleary Bradley, Friend, & Gottman, 2011). All participants were within the range of moderately effective to very effective for increasing confidence based on participants' self-report to incorporate dialogical relationship skills into their relationships.

For the overarching construct of dialogical relationship skills, the results of this study (trend analysis and PEM) suggested a treatment effect across all participants, suggesting that the DREM was effective at increasing confidence based on self-report with individuals from low SES households regarding dialogical relationship skills. Two out of the five participants stabilized with their highest score during the postintervention phase, while three out of the five participants continued with a consistent increase during the postintervention phase. The increase that continued during the postintervention phase suggests it is possible that the information learned during the DREM intervention was integrated further after the treatment phase, although a longer-term longitudinal study would be needed to strengthen this finding. Similar to Boyd et al., (2006) participants feedback in this study appeared to support the use of psychoeducation. Participants consistently communicated that the lessons had been helpful in learning new skills around dialogical relationships. Further, the results suggested that the confidence in the use of these skills continued occurring during the postintervention phase.

Two out of the five participants had a decrease on day four of treatment, suggesting that mutuality may be a harder skill to learn, or at the least, feel as confident

in the skill after one skill-based module. One out of the five participants demonstrated a flatter line suggesting that perhaps the constructs were not as novel, or perhaps she had pre-existing knowledge on the dialogical relationship constructs. A possible influence may be due to the participant's age bracket (i.e., 18-24), which, as a generation may have more exposure to wellness constructs and healthy relationship psychoeducation than other participants who were older. Researchers (Yang, 2008) have found adults in the baby boomer cohort (i.e., older participants in this study) were found to overall report less happiness overall (Yang, 2008). Overall, it seemed that the participants demonstrated different levels of confidence in the dialogical relationship skills, as evidenced by more considerable changes in-between scores. It is possible that the participants reported increased confidence around skills that resonated. For instance, Participant 5 reported her highest skill on day three after the DREM on directness. During her closing call this participant reported how learning to speak directly about her feelings was most poignant of all the skills. She provided an example of how she implemented with her husband and the improved outcome of a difficult conversation she pursued based on the learned skills. She spoke of the module on directness and her increase of understanding that lead to effectively addressing her feelings. She reported feeling more confident and capable of using directness, as evidenced in her reported scores.

Relationship Satisfaction and Dialogical Relationship Modules

Within the group of participants, two participants demonstrated an increase and three participants demonstrated a decrease in their relationship satisfaction. Interestingly,

one participant's scores demonstrated a negative trend during the treatment phase before shifting back in the direction of the baseline median. Although the results related to RQ1 supported the Boyd et al. (2006) finding that participants indicated psychoeducational programs were integral to effective treatment, the results of RQ2 seem less clearly in support of this intervention. In fact, there is an argument to be made that the DREM intervention may have decreased relationship satisfaction for some participants. Other participants had some initial decrease but then limited variability, suggesting that the initial psychoeducation may have led individuals to rate their relationship more negatively compared to baseline, with subsequent modules having little impact.

Interestingly, results of relationship satisfaction were mixed. For participant 1, for example, the intervention and postintervention scores suggest that Participant 1 had an increase in relationship satisfaction from the DREM intervention, consistent with previous literature on couple and relationship education (CRE), focused on relationship skills where individuals from low SES households reported greater relationship satisfaction as a result of psychoeducation (Cleary Bradley et al., 2011). Other participants, however, had strikingly different findings. For the remaining four participants, a negative trend emerged during the intervention. These findings suggest that, for some individuals, learning about a healthy relationship, in fact, decreased reported relationship satisfaction. One possible explanation is that learning about facets of a health relationship highlight problematic aspects of their current intimate relationship, raising consciousness about problems that exist.

Quality of Life and Dialogical Relationship E-learning Modules

Treatment efficacy was highly varied across participants, with two participants showing a clear increase in QoL scores, one other showing a debatable treatment effect, and two others showing no improvement in QoL scores. One participant (Participant 5) had interesting findings. She reported a complex and extensive life experience with poverty resulting in her training herself to being positive despite contextual difficulties. Consistent with this, her scores tended to be higher than other participants with limited variability. This is consistent with what has been found in previous studies where older individuals tend to report greater wellness and resilience than their younger counterparts (Fullen & Granello, 2018). Fullen and Granello (2018) found that individuals who had experienced more historically or lived during a certain context were more likely to have a greater subjective wellness. What is currently unknown and warrants additional attention is the extent to which such heightened scores represent a heightened sense of positivity or a defense mechanism. There is some evidence that some individuals from low SES backgrounds develop greater resiliency (Brody, Yu, Miller, & Chen, 2016; Vyas & Dillahunt, 2017).

E-learning as an Effective Delivery Method

As established by Abid (2008), a function of e-learning is the ability to overcome possible barriers experienced by individuals from low SES groups. For instance, the dialogical relationship e-learning modules were designed for daily completion by participants during a convenient time to them, accounting for busy schedules, single-

parent demands, and other time restrictions. Further, as anticipated, the e-learning modules involved a nominal cost to the researcher and served as an innovative strategy of reaching individuals from low SES communities (Ralston, Andrews, & Hope, 2018; Stracke, 2019).

Initially, Canvas was utilized as the primary method of delivery, but due to some technical complications, email proved to be the simplest delivery method. Ultimately, this proved the most efficient and effective way to deliver the content and assessments to meet the needs of this population best. As expected, e-learning allowed the research to meet participants in a way that addressed structural barriers. Traditionally accessing mental health services such as living in rural areas, the therapist "dead zones" (i.e., geographic areas where there are no therapists or limited numbers of therapists), lacking health insurance or high deductibles, financial and life strains, and mental health stigma among individuals from low SES groups (Fiscella et al., 2000; Thoits, 2005). Participant 5 reported that she would have never been able to afford to go to counseling to obtain something similar to the DREM. Further, feedback from two participants (Participant 4 and 5) reinforced the usefulness of the resource and suggested a good fit for future delivery formats of the DREM.

Limitations of the Study

As an exploratory study, this study aimed to fill a current gap in the literature and practice – interventions developed for and focused on individuals from lower SES groups. While SCRD offered the ability to examine the effectiveness of the DREM, it has

limited generalizability. Further, more research focused on both the dialogical relationship skills and e-learning delivery method are needed to enrich the findings of this study.

An additional limitation has to do with the potential of testing effects. That is, it is possible that participants became more familiar with the assessments, and that had some impact on increasing scores through the intervention and postintervention phases. Subsequent research on the topic might include individuals completing the assessments without the intervention to begin to parse out whether the self-reported gains made by individuals are more a function of the intervention or testing effects.

The measure used to assess the dialogical relationship skills was explicitly developed for this study and needed to go through formal development and validation. The content of the DREM and the corresponding instrument used was reviewed by experts. While several consultants reviewed the questions, the instrument was researcher-developed and further research needed for construct and content validity as outlined by the literature (Almanasreh, Moles, & Chen, 2019). Additionally, the DREM was beta tested with a person from within the community. Notwithstanding, the findings encourage further research as this practice-oriented nature is valuable and may help in closing the gap by working with underserved individuals within low SES groups in a more expedited manner.

To examine long term effects, the researcher originally designed the study for a four-week duration for each participant. The length of the study was shortened to fit the academic semester after an initial delay in the recruitment process. The project was

adapted to the delay in recruitment strategy. Although the study was shortened from the original intended timeline, research supports that the length of the intervention is not as significant in effectiveness of treatment (Zemp, Merz, Halford, Nussbeck, Gmelch, & Bodenmann, 2017). Further, the exploratory nature and SCRD methodology allowed for the researcher to examine the benefit of creating a more extended intervention and developing future research of the DREM.

Recruitment language initially contained possible shaming labels. While unintentional, researchers should be careful not to include language that could be misconstrued or deemed offensive, such as an included label of "low SES" within recruitment material or consent form. An alternative is to describe possible characteristics within individuals from low SES. For instance, describing criteria of inclusion such as individuals that use government social programs like Children's Health Insurance Program. Another factor of consideration are the many individuals within low SES households that may not have access to reliable internet.

Additionally, while all participants were fluent in English, four out of the five also had a second language. It is possible that a secondary language conflated meanings and definitions when considering their responses - leading to some lack of clarity that may have impacted responses.

Of import to note is the study was completed prior to current COVID-19 pandemic. It is relevant to consider the context in history in which individuals complete the DREM. It is possible that at a different time participants may have been more receptive or able to incorporate dialogical skills. With current reports of increases of

domestic violence, suicidality, depression, and other mental illness (Taub, 2020; Rajkumar, 2020), it is imperative that more tools and services are provided in a culturally appropriate context for individuals of low SES households—often experiencing greater stressors in personal relationships (Maisel & Karney, 2012).

Ultimately, Facebook was the primary source of recruitment, and 4 out of the 5 participants that completed the study were obtained through the social network platform. This lead to possibly recruiting a specific pocket of individuals that, through connection to a social network (e.g., a friend of a friend), were highly motivated to participate in and complete the study. It is unknown how they may be systematically different from those less intrinsically motivated to participate in the study.

Implications for Counseling and Suggestions for Future Research

Based on the main findings from the study, several suggestions and directions emerged for counselors, counselor educators, supervisors, and researchers. The significances are organized as follows: (a) recommendations for counseling and (b) suggestions for future research.

Recommendations for Counseling

Research and counseling go hand in hand and are foundational to our profession. Counselor educators, specifically, are at the frontline of training counselors-in-training with ways to address and meet the needs of underserved populations. A key component to bridging the gap with underserved populations is practitioner-oriented and action research (Guiffrida, Douthit, Lynch, & Mackie, 2011). Action research is defined as an

approach that is collaborative with those traditionally to whom have been researched. Through this shift from our training, we have the potential of empowering future counselors and, accordingly, decrease the disconnect between research and practice (Guiffrida et al., 2011).

Essential for counselors working with individuals of low SES is leaning into the exemplifying elements of the therapeutic relationship. Intrinsic to the relationship between counselor and client is the counselors' opportunity to provide clients an experience of confirmation through the dialogical relationship (Friedman, 2002). Additionally, the use of technology to provide tools, interventions, and resources for individuals from the community is necessary within our counseling profession. Participant 4, reported "As a mental health consumer of all my life, it is in my 30s that I am finally able to hear and integrate the different coping skills and tools out there…Videos of the coping skills, where I was able to see someone [the researcher] was very helpful." Participant 4 reported these accessible resources and skill training material is what she would like to see more of. The finding in this study might encourage counselors to use more technology-based interventions and creative methods to reach underserved populations. Of import to note is technology and strategies of reaching underserved populations often need not be complicated and in fact are detracted by fancy technologies (Watters, Haninen, & Hardin, 2011). Ultimately, although research is limited on how much technology contributes to closing the gap of mental health services within underserved population, sufficient support has been demonstrated suggesting counselors need to critically consider the ways they may expand their reach through

technologies (e.g., telehealth, technology based self-help; Ralston, Andrews, & Hope, 2018).

Suggestions for Future Research

From the results of the study, there is some preliminary evidence of a positive impact of the DREM, particularly related to increasing confidence in the ability to use the dialogical relationship skills. Therefore, a next step is completing more rigorous research on the intervention (Bernal, 2006). Although the first phase, according to Bernal (2006), of developing a cultural intervention was fulfilled by this study, there are a number of ways to extend this research. For example, there remains a need to refine and validate the dialogical relationship measure. The first step to validating the dialogical relationship measure is to examine construct validity. The initial steps of content validity which are domain identification, item generation, and instrument formation, were completed in this study. Next steps include having a Judgement-quantification, which according to Almanasreh et al. (2019), entails having a group of experts evaluate the instrument domains and establish the sufficiency of the included items.

Additionally, it may be important to extend outcome measures beyond how confident an individual is in using the skills, to address whether there is an objective increase in skill usage of the relationship, both in frequency and quality of the skill. More objective assessment of relationship skills might provide. Furthermore, the study highlighted the possible broadness of the relationship satisfaction component of this

study. Future studies should focus on relationship connectivity as a more direct effect and focus of dialogical relationships, and by extension, DREM intervention.

Further, a long-term effect of the Dialogical Relationship skills has not been studied to understand the efficacy of the treatment and long-term effects of the integration of Dialogical Relationship skills. Another research recommendation is further understanding of components of effective e-learning within counseling. In their study on the effectiveness of developing a community-based research network in Alabama, Watters et al. (2011) make suggestions of ways to effectively collaborate with community networks - The Alabama Entrepreneurial Research Network (AERN). The main objective of AERN was to work through established structures to close the gap between academic and community approaches. Of import is the attunement of the researcher to understand the sensibilities of the local community, their expectations, and leadership style. Future studies, therefore, of DREM and other treatment interventions for individuals of low SES would benefit from this community network approach.

An unexpected function in the recruitment phase developed in the current study. During the initial phase of contact, after IRB approval, several organizations responded closed to the promotion of the study citing the communities' well-being as the rationale for not participating in promoting the study. A future direction for research, therefore, is an interdisciplinary approach that utilized university, organization, and community stakeholders' assets (Watters et al., 2011). It is integral for researchers in counseling to develop collaborative relationships and establish partnerships within organizations serving low SES communities – Community-based participatory research (CBPR).

Academics and researchers can be agents of change and involved with social action through CBPR. Ultimately, CBPR is established as an action-oriented research approach founded on the principals of critically considering the socially constructed stances through research (Nicotera, Cutforth, Fretz, & Summers Thompson, 2011).

Future research studies with individuals of low SES demand utilizing collaborative community-based research. Conclusively, the shift from academic research to remain within the academy is outdated and does not provide transformative work. On the other hand, researchers that have embraced community-engagement research have reported a greater enthusiasm for their research agenda (Nicotera et al., 2011). With the overlap of minority identities and low SES, future studies should include multilinguistic approaches.

Conclusion

The purpose of this study was to develop a culturally appropriate intervention for individuals from low SES groups. The researcher intended to determine the value of future studies surrounding the development of relationship satisfaction as a means of increasing quality of life. Overall, while nuances appeared in each participant's results, participants reported, on average, .95 PEM score for the effectiveness of the dialogical relationship e-learning modules, indicating robust change in perceived confidence of using these skills. Demonstrating that the skills were clear and influenced the participant's ability to implement.

With this first step of closing the gap within interventions for individuals of low SES groups, the researcher aimed to incorporate cultural context within the intervention development (Cook & Lawson, 2016). As demonstrated in this study, the development of interventions specifically aimed to meet the needs of individuals of low SES is necessary in order to ethically meet the needs of the group of the population (Wang, Locke, & Chonody, 2013). Simply stated, re-packing or continuing to utilize interventions normed within higher-SES groups invalidates the differences of lived experiences between such individuals and those of low SES and does not suffice (Liu, 2004).

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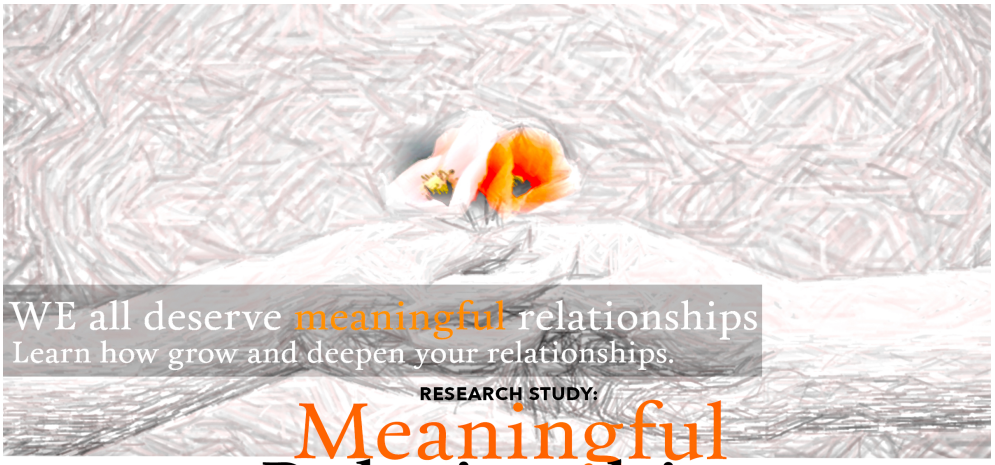
APPENDIX A

RECRUITMENT FLYER FOR PARTICIPANTS



RESEARCH STUDY:

Meaningful Relationships

Potential Benefits:

~ Strengthening relationship skills
~ Increase the ability to create healthier, more connected and meaningful relationships
~ Increase awareness of professional and community resources

Payment Compensation:

~ Participants that complete screening documents along with the first 3 assessments, will receive a $ 15 VISA gift card
~ Additionally, a $10 VISA gift card is provided for each completed module + survey (up to $40)
~ A $25 VISA gift card at the completion of the remaining 3 assessment (post-modules)

Want to make your relationships stronger?

A new year means time for a BOOST into healthier relationships. Sign up for a FREE online class. 10 days - learn skills to create meaningful connections and build stronger relationships.

ONLY 8 slots are available!

Individuals that qualify and are invited will participate - upon their consent - in a new study that aims to understand the impact of Meaningful Relationship classes in their life.

What the study will involve:

~A maximum of 8 participants will be selected
~ Participants will participate in an E-learning class that supports relationships growth
~ The study will take 10 days.

~ 1 phone screening and initial survey
~ 3 surveys prior to study's 1st lesson
~ 4 E-learning lessons with 4 surveys
~ 3 surveys post E-learning modules

Who can participate?

You must have a household income of under $30,000, be at least 18 years of age or older, speak English, have reasonably easy access to the internet, be free of any self harming thoughts or severe mental health issues, and self-identify as being in an at least 1 intimate or close relationship.

Duration and Venue of Study:

All parts of the class and study will be completed online. An initial phone call will be established where you can ask questions and receive more detailed information. The study will begin as soon as you qualify and continue until completed (10 days for each participant).

If interested, call Angiemil Perez Pena, from the University of North Carolina at Greensboro at ***(678) 464-1994 or email at a_perezp@uncg.edu***

Revised 2.19.20

APPENDIX B

SCREENING QUESTIONS GUIDE

(Note: Screening question guide will be used by researcher to determine eligibility of subject for participating in current study).

1) Are you at least 18 years of age?
2) If this call gets disconnected, what is the best number to contact you back?
3) Do you speak fluently English?
4) Do you identify as being low-income?
    a. What do you earn within a year?
    b. How many people live in your household?
5) What was the last grade you completed of education?
6) Do you have easy access to the internet?
    a. Where do you most often access the internet?
7) Are you currently having thoughts of killing yourself?
    a. Have you had any thoughts within the last 6 months?
        i. When was the last time you had thoughts of killing yourself?
        ii. If yes, SIMPLE STEPS will be used for referral to mental health resources. If necessary, mobile crisis will be contacted.
8) Do you currently experience any form of abuse within your intimate or familial relationships?
9) Have you ever been diagnoses with a mental illness?
    a. If so, when was that diagnose provided and by whom was it diagnosed?

APPENDIX C

INFORMED CONSENT

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO
CONSENT TO ACT AS A HUMAN PARTICIPANT
Project Title: Exploratory Study on Brief Dialogical Relationship Psychoeducation for Individuals of Low SES

Principal Investigator: Angiemil Perez Pena, MS, NCC; LPCA
Faculty Advisor: Dr. Craig Cashwell, PhD

What are some general things you should be aware of the study?
You are being invited to participate in a research study. Your participation is completely voluntary and can be terminated at any point. You may choose to not join or withdraw your consent at any point - for any reason and without NO penalty.

Research studies like this one are designed to help understand a special population or to generate new knowledge. The hope is that you benefit directly from this study but this may not be the case and any decision to leave the study would not impact your relationship with UNCG. There is minimal risk foreseen in this study, but research, in general, may have a risk.

Due to the nature of providing education and information regarding an individual's process of thinking, through this study, participants may experience growth as a result of participating in this study. Like all growth, at times, those around us may not be ready to grow with us. Participating and engaging, therefore, in the content of the modules may challenge relationships within which you exist. If at any time you experience distress or if conflict emerges due to the incorporation of relationship skills, you may choose to end your participation in the study. Please note that this study is not intended for individuals in violent domestic situations (romantic or familial).

Details of the study are disclosed in this consent form and your understanding of the details is important so that you may make an informed decision. You will be offered a copy of this consent form. If you have any questions about this study you should speak to the researcher named in this study and their contact information is below.

What is the study about?
The study aims to understand the impacts of providing information and education about mutual relationships and the effects it may have on individuals that identify as being from a household income of $30,000 or less.

Why are you asking me?
You are being asked to participate in the study (1) self-identify as being from a household income of $30,000 or less; (2) be at least 18 years of age or older; (3) speak English; (4) have reasonably easy access to the internet to allow them to participate fully in the intervention; (5) meet the cut offs of (approx. a household income of $30,000 or less) based on occupation, income, and education as outlined by the *Bureau of Justice Statistics U.S. Department of Justic*e; and (6) self-identify as being in an at least 1 intimate or close relationship;

What will you be asking me to do if I agree to be in the study?
You are asked during approximately four weeks to:

- Completing an initial phone screening with the researcher, followed by completing a demographic questionnaire.
- Complete 3 assessments prior to engaging with the education and information regarding an individual's process of thinking provided to you.
- Complete 4 psychoeducation modules (chapters) providing you with education and information regarding an individual's process of thinking.
- Complete 4 assessments during the process of completing the 4 modules.
- Complete 3 assessments after the process of completing the 4 modules.

Education and information provided via the modules:

- Skills to communicate more directly.
- What mutual relationships look like.
- How being open impacts your relationship satisfaction.
- Overall, a greater sense of what meaningful relationships can look like and tools to strengthen your relationships.

If you have questions, want more information, or have suggestions, please contact Angiemil Perez Pena at (678) 464-1994 or email a_perezp@uncg.edu or faculty advisor, Craig Cashwell, PhD at cscashwe@uncg.edu.

If you have any concerns about your rights, how you are being treated, concerns, or complaints about this project or benefits or risk associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855) 251- 2351.

What if I feel any distress during the time of completing this study?
This study may include minimal risks such as distress. If any mental health concerns emerge please contact Sandhills Center at (336) 832- 9700 for information of local mental health resources.

OR

If you need to speak to someone regarding immediate distress please contact:

Crisis Call Center
(775) 784-8090 or text ANSWER to 839863
Crisis Call Center's 24-hour, 7 day, 365 days a year crisis line is here to provide a safe source of support for individuals in any type of crisis

Depression Hotline
(630) 482-9696
Suicide Prevention Services of America is one of only seven organizations in the United Sates devoted to saving lives and restoring hope through prevention, intervention and postvention.

SAMHSA: National Helpline
(800) 662-4357
SAMHSA's National Helpline is free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorder

IF an Emergency, please call 9-1-1 !!!!

What benefits are there to be participating in this study?
There may be both benefits to you and society due to your participation. Through participating here, we hope to develop better interventions for individuals from a household income of $30,000 or less in order to strengthen their relationships. Through your participation, you may experience benefits to your personal relationships as you learn to better communicate and have stronger mutual relationships which may have impacts in your overall well-being and life satisfaction.

Will it cost anything? Will I get paid?
The cost of this study should not be any. Communication will be done online messaging and alternatives to texting exist. You will need to have access to the internet but can be connected to resources in the community where access is free. All participants that complete the first three assessments and screening documents will receive a $15 Visa gift card. Additionally, participants have the opportunity to earn a $10 Visa gift card for each module completed at the end of the completion of the study (up to $40). Further, participants that complete the last three assessments post modules will receive another Visa gift card of $25 (total potential gift card value of $80 upon completion of study).

How will your information be kept confidential?
All data will be housed in Qualtrics and Box. These are secure clouds that are encrypted. Additionally, all participants' names will be changed to mask identity with coded names kept in a password protected computer.

Data from this project will be written and used for educational purposes. All information obtained in this study is strictly confidential unless disclosure is required by law.

Will my de-identified data be used in future studies?
Your data will be stored for five years following the closure of the study. Your data will be destroyed at May, 2025. De-identified data will not be stored and will not be used in future research projects.

What if you want to leave the study?
You may leave the study at any time without penalty. You have the right to refuse to participate in the study. You may request your data be destroyed. You will receive a Gift card only if you have completed the corresponding phase of the study (i.e. $15 visa gift card after the first 3 assessments and screening documents completed). The researcher also has the right to remove you from the study if, for instance, signs of distress are reported or if you failed to follow directions, or for failure to following instructions. If you are removed from the study for failure to complete modules, no compensation will be provided.

What about any changes or new information to the study?
If significant changes were made to study you would be immediately notified.

Voluntary Consent by Participant:
By verbally consenting, you are agreeing that you have read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By consenting, you are agreeing that you are 18 years of age or older and are agreeing to participate.

Principal Investigator _____ Date _____

APPENDIX D

SAMPLE DATA COLLECTION SCHEDULE

February 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	**3**	**4**	**5**	**6**	**7**	**8**
9	**10**	**11**	**12**	**13**	**14**	**15**
16	**17**	**18** Screening + B1	**19** B2	**20** B3	**21** M1/T1	**22** C1-M2/T2
23 M3/T3	**24** M4/T4	**25** P1	**26** P2	**27** P3	**28**	**29**

B1-B3: Data collection before intervention
T1-T4; M1-M4: Data collection during intervention; Modules 1-4
P1-P3: Data collection post intervention

APPENDIX E

SES INDEX 3

Measures	**Index 3**
Education	❑ 0: Less than high school ❑ 1: High school, some college, associate's degree ❑ 2: Bachelor's degree ❑ 3: Master's, professional, doctorate degree Possible range: 0-3
Income (percentage of Federal poverty level)	❑ 0: 100% or less ❑ 1: 101%-200% ❑ 2: 201%- 400% ❑ 3: 401% or greater Possible range: 0-3
Employment	❑ 0:Unemployed past 6 months ❑ 1: Employed past 6 months Possible range: 0-1
Possible range	0-7

(Berzofsky, Smiley-Mcdonald, Moore, & Krebs, 2014)

Note: Index 3 – completed by researcher from participant's demographic questionnaire

APPENDIX F

DEMOGRAPHIC QUESTIONNAIRE

1. **What is your age?**
a. 18-24 years old
b. 25-34 years old
c. 35-44 years old
d. 45-54 years old
e. 55-64 years old
f. 65-74 years old
g. 75 years or older
2. **With which gender identity do you most identify?**
a. Female
b. Male
c. Transgender female
d. Transgender male
e. Gender non-conforming
f. Not listed_____
g. Prefer not to answer
3. **Ethnic origin: Please specify your ethnicity.**
a. White
b. Hispanic or Latino
c. Black or African American
d. Native American or American Indian
e. Asian / Pacific Islander
f. Other
4. **Education: What is the highest degree or level of school you have completed?** ***If currently enrolled, the highest degree received.***
a. No schooling completed
b. Nursery school to 8th grade
c. Some high school, no diploma
d. High school graduate, diploma or the equivalent (for example GED)
e. Some college credit, no degree
f. Trade/technical/vocational training
g. Associate degree
h. Bachelor's degree
i. Master's degree
j. Professional degree
k. Doctorate degree
5. **Marital Status: What is your current marital status?**
a. Single, never married

b. Married
c. Committed relationship
d. Widowed
e. Divorced
f. Separated

6. Employment Status: Are you currently…?

a. Employed for wages
b. Self-employed
c. Out of work and looking for work
d. Out of work but not currently looking for work
e. A homemaker
f. A student
g. Military
h. Retired
i. Unable to work

7. If out of work, have you been out of work over 6 months?

a. Yes
b. No, I have been out of work less than 6 months

8. As you complete the study on dialogical relationship think of 1 person to use through the study who you identify as close or intimate. What is your relationship with this person?

a. Partner
b. Friend
c. Relative
d. Other _____

9. What is your total combined family income for the past 12 months, before taxes, from all sources, wages, public assistance/benefits, help from relatives, alimony, and so on? If you don't know your exact income, please estimate. (Check one box)

a. Less than $5,000
……..
b. $5,000 - $10,000
……..
c. $10,000 - $15,000
…….
d. $15,000 - $20,000
…….
e. $20,000 - $25,000 ……
f. $25,000 - $30,000 ……
g. $30,000 - $35,000 ……
h. More than $35,000
……..

i. Don’t know or choose not to answer
……..

10. How many people are currently living in your household, including yourself?

____

APPENDIX G

DIALOGICAL RELATIONSHIP PSYCHOEDUCATION ASSESSMENT

In answering each question, consider the single most important person in your life.

Presentness is the ability through practice to cultivate our full attention in the present moment. It is to be completely and fully embodied (i.e., aware of all of our present moment experiences). It is to bring our attention and intention to the present moment.

Directness refers to authentically and honestly sharing our thoughts and feelings. It means that we can listen to others and share with others how we really feel. The intention is to understand and be understood.

Openness refers to being authentically as we are in a way that allows for our voice to be heard. When we are open, we are transparent (without pretense). It is the act of being our full self and when we invite others to their full selves.

Mutuality refers to the bidirectional (two-way street) of feelings and actions exchanged between individuals. When we are in a mutual relationship, we feel a sense of zest, empowerment, clarity, self-worth, and connection.

Check all that apply. At this time, check all modules that you have completed.

- ☐ No modules completed
- ☐ Presentness.
- ☐ Directness
- ☐ Openness
- ☐ Mutuality

Answer questions 1-9

5-point Likert Scale (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree)

1. I know how to be fully present.
2. I am able to be fully present in most situations.
3. I know how to be direct in my relationships.
4. I am able to practice directness in my relationships in most situations.
5. I know how to be open in my relationships.
6. I am able to practice openness in my relationships in most situations.
7. I know how to have mutuality in my relationships
8. I am able to practice mutuality in my relationships in most situations.

9. Overall, the e-learning modules achieve intended learning outcomes.

APPENDIX H

RELATIONSHIP ASSESSMENT SCALE

Please mark on the answer the letter for each item which best answers that item for you. In answering each question, consider the single most important person in your life.

How well does your partner meet your needs?

A	B	C	D	E
Poorly		Average		Extremely well

In general, how satisfied are you with your relationship?

A	B	C	D	E
Unsatisfied		Average		Extremely satisfied

How good is your relationship compared to most?

A	B	C	D	E
Poor		Average		Excellent

How often do you wish you hadn't gotten in this relationship?

A	B	C	D	E
Never		Average		Very often

To what extent has your relationship met your original expectations:

A	B	C	D	E
Hardly at all		Average		Completely

How much do you love your partner?

A	B	C	D	E
Not much		Average		Very much

How many problems are there in your relationship?

A	B	C	D	E
Very few		Average		Very many

NOTE: Items 4 and 7 are reverse scored. A=1, B=2, C=3, D=4, E=5. You add up the items and divide by 7 to get a mean score.

(Hendrick, Dicke, & Hendrick, 2011)

APPENDIX I

BRUNNSVIKEN BRIEF QUALITY OF LIFE SCALE

The following 12 questions are about how you experience your quality of life. It covers six areas, how satisfied you are with these, and how important they are to you. Circle the number that best reflects your experience.

		Do not agree at all				Agree completely
1	I am satisfied with my **leisure time:** I have the opportunity to do what I want in order to relax and enjoy myself.	0	1	2	3	4
2	My **leisure time** is important for my quality of life.	0	1	2	3	4
3	I am satisfied with how I **view my life**: I know what means a lot to me, what I believe in, and what I want to do with my life.	0	1	2	3	4
4	How I **view my life** is important for my quality of life.	0	1	2	3	4
5	I am satisfied with opportunities to be **creative:** to get to use my imagination in my everyday life, in a hobby, on the job, or in my studies.	0	1	2	3	4
6	Being able to be **creative** is important for my quality of life	0	1	2	3	4
7	I am satisfied with my **learning:** I have the opportunity and desire to learn new, exciting things and skills that interest me.	0	1	2	3	4
8	**Learning** is important for my quality of life	0	1	2	3	4
9	I am satisfied with **friends and friendship:** I have friends that I associate with and who support me (as many friends as I want and need).	0	1	2	3	4
10	**Friends and friendship** are important for my quality of life	0	1	2	3	4
11	I am satisfied with **myself as a person:** I like and respect myself.	0	1	2	3	4
12	My satisfaction with **myself as a person** is important for my quality of life	0	1	2	3	4

(Lindner et al., 2016)
The BBQ may be used freely and without cost by researchers and clinicians. For more information visit www.bbqscale.com

APPENDIX J

DREM TRANSCRIPTS

Presentness

Presentness and present being. Today we are going to be talking about the practice of being present within ourselves and our relationships.

Overview Slide

When we are preoccupied we in fact kind of lose sense of the time and with today's lesson is the aim is how do we gain back a sense of being in the moment and in an awareness that brings more color to our life. So, let's talk about what is presentness and what is being present?

To give you a definition, it is the ability, through practice to cultivate our full attention in the present moment. It is to embody our bodies completely and fully. (Definition slide). When we bring our attention and intention. Our attention and intention into the present we are what we call, present, present being, presentness. And that comes through practice and when we are fully present, we are fully awake. Let's take a moment and jot down, what you heard, from that definition.

Pause Video, in your words, what is presentness?

When I am aware, I am aware, I can be aware my intra kind of experience. My psyche, my body. What am I feeling? Am I hungry? Do I have a headache? And so on. So often we are suppressing our feelings and that is the opposite of presentness. To be present is to acknowledge what we are experiencing in a way that brings us more truthfully to the moment.

Being able to tell a spouse, a co-worker, or whomever, Hey, I am experiencing this right now. Or I perceive this to be this way. Then that allows us to acknowledge whatever limitation that may be experienced in that moment.

Let's visualize

We are going to do this exercise, this visualization. Let's imagine, whatever it is for you. Let's say you come from work, let's say that you have a night time work, when you come off working at night and you have whatever house duties you have at home and you have arrived and you are considering what it is that you have to do for the next day. You have not eaten, you have not noticed that you have been on your feet all night. Maybe you have not noticed that you have an ache in your body. So, without being aware think about

how that next interaction goes with your spouse or your children, or whoever you interact, or your roommate or whoever you are interacting at home after work. How does that usually go?

Take a moment, consider what usually happens.

Hopefully you wrote down a couple of feelings or a couple of ways that scenario goes. Now, for you it may be that you do not work at night, it may be a day shift, it may be that you finished several shifts back to back, and that is okay. So, use your example and your experience for this. Now, I want you to take the same scenario and imagine taking a moment when you got home and you closed your eyes and you kind of just take a moment to say, "Wow, I am tired." Now, acknowledging that does not change the fact you are in fact tired. It does not change the fact that you have to go home and do some home duties but it does bring into the room, or into your awareness, "Hey Angie, you are really tired, you are really feeling edgy." (Presentness helps slide). Time of practicing and slowing down and checking in with yourself. I am going to propose to you that it would make a difference, in fact, I know it is going to make a difference.

Let's practice, Five Senses

We are going to do an exercise that you are going to do by yourself or you can do with someone else and it is called the five senses. So, the five senses, in essence is when we slow down and we use our five senses to bring our bodies back into the present.

5 senses

VO- Pause the presentation here, and go through this exercise.

Just taking a moment to account for how you are feeling in the moment.
Lastly, I want to go over making this next couple of days after the video I want you to take a moment. And I want you to make a smart goal.

Smart Goal Slide

I want you to be specific. So, keep it simple. I want to be present every day after work. That is a very simple, obtainable. I want you to make it measurable. I want you to say, for five minutes, after work, every day this week, I am going to take those five minutes. Every day after work, five minutes, got it. I want you to make it achievable. So, making it something that I am able to accomplish. Like the five minutes feels reasonable. I want you to make something that you feel is relevant. The next one (SMART slide again) is time-bound, I want you to set yourself a time.

Before we go, homework…

I am going to give you three questions in your handout that I want you to consider completing before your next lesson. Thank you, my name is Angiemil Perez Pena and I appreciate your time. Have a great day.

Thank you Slide.

Openness

Thank you for joining us, this is Angiemil Perez Pena. Today we are talking about openness.

Overview Slide

In an Instagram world, were everything seems perfect it seems like being open and vulnerable is a hard and counter-culture thing to do. Related to presentness and directness, we are talking about having the ability to have an open heart within our relationship in a way that enhances the way we communicate, the way we express ourselves, the way we feel towards each other. Openness refers to the ability to show up openly and transparently. (Openness definition slide). Talking about openness, I want you to think about expressing yourself as you are, presenting yourself as you are. When we speak of transparency, we think of a glass where we can see through and we can see who the person really is. You can see my true and authentic self, versus this kind of Instagram perfect.

Openness definition.

To be open and vulnerable is to allow ourselves to be seen and to see other's inner and authentic self.

Let's visualize

I want you to consider a person that you have met, maybe it is at work, maybe you did an interview that you felt very nervous, and that there was this feeling that you had that you to show your "best" self, as we sometimes say. Well your best self often does not include your full self. Which is, you know what, sometimes I am not the nicest. Sometimes I am not as kind or patient as I would like to be. In those scenario, in those spaces, we can imagine ourselves to be a little more closed off. Sometimes we can even be our body language closed off. Imagine that feeling, I just want you to bring that kind of to your visualization of your mind.

Pause The Video – Visualization Exercise prompts.

So we can imagine like a big circle, if you think of your central part, your heart, your vulnerable side, that is something we tend to keep to ourselves many times. Now when we are in relationships with spouses, with best friends, roommates, sisters, it can be very hard to have a relationship when you are closed. I want you to imagine if you have a big circle here (motions to central part of body) and that kind of represents your openness. And when we feel closed off and literally our circle closes, our hearts closes up, we are closed off. Openness is when we are exercising that availability, that permission to enter into relationship with, and to be seen.

Now I want you to imagine a person. We already have imagined a person that makes us feel closed off. Try to visualize someone that makes us feel closed off. That maybe we interact with but we maybe feel shy or timid or nervous, and we feel like we cannot make a mistake in front of them. Now I want you to think of the opposite. I want you to think of a person that when you are with them you can just be yourself. You can let it lose and be who you are. And when you are in that space you feel very connected, very open to showing all of you.
Openness allows for your FULL self to be seen.

I want you to imagine this person where you feel open towards. Where you feel this heart section, this vulnerable sections feels kind of comfortable to expose itself.

Remember…

In openness we can show up as our true self and we are able to allow others to see us in this way. And we see others without judging in that way. So, when you visualize that person, when you think about that person, think about how they make you feel. When you are feeling open, how is it that you feel? Do you register that in your body? Do you know how this person communicates to you that they are safe for you to be open?

Pause Video- Prompts

Recap- VO When we are open we allow others to see the real self.

To practice to do with individuals and people that have identify themselves as save because not everyone has earned that space.

Before we go, homework…
Openness Level – VO

Of course we have to practice. So, let's do an openness level exercise. This is going to be your homework. You are going to identify 1-3 individuals with whom you feel most open. Remember that these are individuals that have proved with time and consistency that they are safe individuals. After you have identified 1-3 individuals, I want you to

pick 1 out of those 3 that you want to try practicing being more open with. So now you have your person and you are going to go ahead and use scaling question to see how open you feel. Think of openness as what we talked about, the symbol of your heart being open, a big circle, or your heart being closed, very small. 1 being I am the rate of I am so closed off, and 10 being I am as open as I can be, as transparent as I can be. Rate, how do I feel with this person 1 being not open at all and 10 being very open. Now that you have your score, you are going to set the goal to practice increasing your openness level with that person by 1-2 points. You want to make it a smart goal, so we are trying something that is realistic. So, we are trying 1-2 points. If you are at a 3 you want to work to get to your openness level at 4. There are going to be times that you come in and out of that and that is okay but we are working towards it over the next few days, and of course over the next few weeks and hopefully moving forward. As you practice with this person try and sharing something about yourself that is a challenge but is low-stakes so you are not going to share something that is super hard, super traumatic for us, but we are sharing something that simply may be a little more honest than we usually are. Instead of saying I do not know what I want to eat, maybe I am going to say I don't actually want to eat this kind of food. Whatever, it may be keep it low-stakes. And notice how it feels differently in your body remembering back to our visualization of what we identified of how we feel when we feel open. Notice those things as you practice and good luck as you continue to incorporate these different elements in creating a healthier and stronger relationships around you. Thank you for joining us, this is Angiemil Pérez Peña - **Thank you slide**

Directness

Hi, thank you for joining us my name is Angiemil Perez Pena and today we are talking about directness. We are going to go over the definition, we are going to do a visualization, we are going to do an exercise, and at the end I am going to give you some homework to incorporate this into your life. It is important to understand that to be direct is not to be abrupt or rude or sometimes be that kind of raw, unfiltered person that we can be.

Then what is Directness?

Directness is based on authenticity and one's ability to be honest and say how one feels in the moment but it also is spoken in a way so that the other person can hear.

Directness speaks to the essence of being blunt, but in a way that is connecting instead of defensive. When we are direct with someone we intend to be understood and to understand. Another component of this is to actively listen. And we will speak about each one of these components throughout today's video.

Directness Slide

It is important to recognize that identifying people that are safe, respectful, and open (Recap slide).

Let's visualize what directness looks for in action. So, let's imagine that you are speaking to a friend, a really close friend, a best friend. Regarding an incident perhaps of an issue between your child and their child. Now of course being a parent you are going to be protective of your loved one. And if you come at it with this attitude of "let me tell you how I feel," it may not land how you think. Right? Remember, that the intention is to be understood and to understand. So, when we go to speak to a best friend. We would be coming with an intention of wanting to express ourselves but to also wanting to understand the feelings and the thoughts that the other person has regarding the situation.

You are coming to your best friend because their child is misbehaving or has somehow hurt your child or anything in that scenario and you are speaking to them regarding their behavior. First thing I want you to remember, is always using I language. So when I am speaking about my feelings, no one can really refute how I feel. However, I do not want to put onto someone else their feelings. I do not want to say, "well you did this… or your son did this, so therefore my kid did this." We want to use I language because it is going to keep the defensive nature that we all have to want to protect our loved one, in a way, disengaged.

I want to use I language when I am identifying my feelings. The reason this is so important is because when we use your language, it is accusatory. What the person is hearing is, "Oh you are blaming me, oh you are telling me that I am wrong." And immediately, when we feel attacked it is natural for us to become defensive.

Directness is going to get to the heart of the matter so I am going to say, "Hey, it is really important to me that I know, that you are taking care of my kid as well as your kid when they are together and I am not present.

Directness vs. Not

So imagine you had this interaction with your best friend but you didn't say what you felt. You were kind of just pushing it down and just saying, "oh it is nothing, not a big deal." The problem with that is that eventually we start hiding ourselves and hiding things that we feel or situations and they accumulate and often come out in the worst timing possible.

I want you to think being direct communication and intention as a prevention of an outcome that perhaps can be more defensive in the later future if we were not to address it.

When I approach a friend, a loved one, or even a stranger, I am doing it with the intention of being understood.

Wait, there is more…

And we are going to practice the skill of active listening. Active listening is also part of being direct. Because to speak to someone, to understand someone, we must listen. What that means is we are not just "mhm, mhm, mhm," but we are actually paying attention to what the other person is saying. When we are listening to what they are saying. When we are listening to what they are saying we are not having our own thoughts or rebuttals or kind of our responses to the person in the back of our minds. We all have been in that situation when we are already thinking of the come back or the quip we are going to say to that person as soon as they stay quiet. Active listening means that I am solely focused, I am only focused on listening to that person.

Homework

Picking a person that you want to actively listen. Maybe it is a best friend, maybe it is a parent, maybe it is a neighbor. Someone that you have some type relationship, good rapport, that you can easily be yourself with. So that you can practice this skill.

When you are listening to the person, I want you to solely listen, and to use your minimal encouragers, which are things such as when we nod our head, or mhm, or I am listening, any one of those works, whatever feels natural to you. Listen to them for an extended period of time and when they are done I want you to just say back what you heard and share with them what you understood before offering any advice or kind of sharing your own story. Ask them, is there any way I can be helpful with this situation. Hopefully that skill combined with I language will be helpful towards you in developing the directness that is helpful to understanding and being understood.

It is natural for us to be defensive and that is the opposite of what we want to do. Another component is to share how we feel. Ah, in the practice exercise we did it was sharing something as small as, I really liked this candy, or I really liked your baking and explaining in detail why or what it is that you like that item.

With everything practice is what helps us to get to the place where it becomes more natural for us so I encourage you to try this out throughout the next couple the next couple of days, and throughout the next couple of weeks and I hope that as you continue to build this you will continue to see the progress not only in identifying how you feel, in communicating how you feel, and hopefully understanding how those around you are feeling in a way that it enhances your relationships.

… But when we give the other person the respect they deserve by sharing how we feel. As you grow in your ability to do so, I believe that it will, little by little make impacts in the relationships that you belong. Remember that directness is to speak with our heart and our intention is to understand and be understood. As always, I want to thank you this is Angiemil Perez Pena.

Thank you Slide

Mutuality

I am Angiemil Perez Pena and today we are going to talking about mutuality.

Overview slide

Today we will cover a little about what mutuality is, what it entails and what are some different ways we can foster it in our relationships. As we know humans are wired for connection. When we speak of mutuality, I am speaking about a bi-directional, a two-way street in the relationship where we both feel heard and seen.

Mutuality Definition

In reality often times we feel like that in keeping a relationship that it is better for our relationship to keep our feelings to ourselves which is the opposite from true. Important to note does not mean that we are equal in power, it could be between a professor and a student, a parent and a child, a teacher and a student. However, we are speaking about being able to see and appreciate that person for who they are and they be able to appreciate us for who we are. (**Mutuality means…)**

When you are in a mutual relationship you are comfortable and confident that you are able to share how you feel without any fear that someone is going to take that against you or hold that against you.

Example 1

Let's think about an example between a teacher and a student. So imagine that a boy is experiencing some bullying in their classroom and is not able to speak to their teacher about this and every time they get in trouble they are reprimanded and they are told that they are the bad boy, that they need to sit out, whatever the repercussion. Well in that case, the teacher is not really having a mutual relationships with this student because they may not be understanding the uniqueness of this person's personality. Are they getting into trouble because they are feeling sad? Perhaps they are getting into trouble because

they feel unseen or unloved in this classroom. In this case, because the student is not able to express how they feel they are not feeling that they are being seen. However, there are not equal in power but if they were in the same scenario in a mutual relationship the teacher would be making time to understand why this student specifically is feeling out of place or is having some behavioral problems in the classroom, etc.

Pause Video – Prompts

Example 2

This is true also in intimate relationships, so let's imagine that we have two friends. So let's imagine that we have two friends. One friend I feel comfortable speaking to about some trouble I am having with a superior at work. This friend is someone that I feel I can share how I feel without being judged or that they are going to kind of just shrug it off and just say like "that is not really happening." It is someone that I feel is going to validate me and is going to listen to me. And on the other hand, I have a friend that I know I have to manage the story. I have to tell them in a way because they might tell me that I am wrong, or they might not listen to me or they may just think that I am being difficult.

Pause Video- Questions/Prompts

In that case, I do not have a mutual relationship, because my full self cannot be present and does not feel safe to show up with that person. However, in the first friend I mentioned, that would be a mutual relationship because I am able to express how I feel and share my full self with that person and we both feel appreciated in that relationship because of so.

When we are in a mutual relationship, we feel energized after the interactions we have with our friend or with that person in relationship that we are. We feel a sense of clarity, of empowerment, of self-worth, and of connection. We have an overall sense of zest. **(Mutual relationships leave…).** In the first example of that relationship, I do not feel quite comfortable, I do not quite feel empowered, I don't quite feel I am going to be validated, therefore, it is not mutual. In the second relationship where I feel I can share myself and know that that person is going to listen to me and hear me and understand me, there is a mutuality, there is a bi-directionality, there is a two-way street there. And this is important to recognize because often we find ourselves in situation where we kind of take responsibility for others characters and behavior.

Before we go… Homework- VO

One more thing before we go. I want you to complete this exercise and take some time in thinking what does it feel to have a mutual relationship. Pause the video here and

consider each one of these prompts and what it feels like over the next couple days to be in a mutual relationship. Really bring this awareness and everything you have learned over the last few modules.

Okay guys, I want you take away a couple of things from this video. We are all built for connection it is part of who we are, it is part of what we crave, but we want to be in healthy relationships, we want to be in mutual relationships. I want you to take away from this week's exercises and lesson an ability to kind of identify those relationships that perhaps are little more life giving, a little more energy giving, more mutual and those perhaps that are not as much. Just pay attention and especially within your inner circle, I want you to just consider how you feel energized and how you feel depleted.

Remember…As you learn…

Most importantly by identifying that one example to start off with of a mutual relationship we learn what it is like to be in a mutual relationship and little by little we are more practiced and more seasoned in identifying healthy relationships wherever we may find them, be it at work, with a co-worker, with a family, with a friend, with a partner and that is what I want for you guys. It takes practice and patience and I am really excited for you and the relationships around you.

Healthy relationships are mutual….

Thank you for time as always, my name is Angiemil Perez Pena and I hope this has been beneficial to you.